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Vol. 9 *January, 1935* No. 1

The BULLETIN

of the

AMERICAN HOSPITAL ASSOCIATION

Incorporated

A monthly official publication devoted to the discussion of Association affairs and to subjects of interest to hospitals and allied institutions

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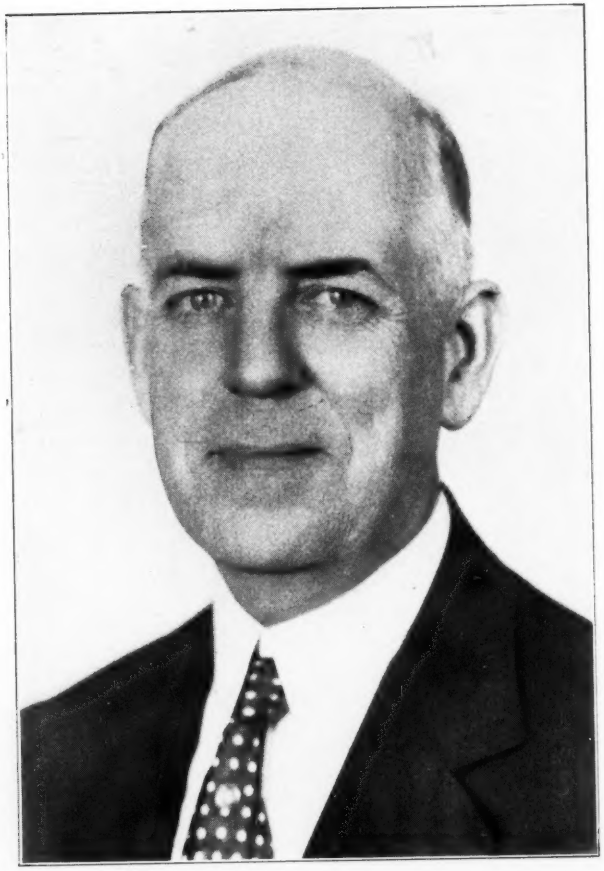

Robert Jolly
PRESIDENT

New Year Greetings

To the Members of the American Hospital Association—

We are entering what I believe will prove one of the most momentous years in our history. We have confronted many problems in the past three or four years. Some of them have been solved; some have not. We are facing problems during 1935 *that will take much thought, time, energy, and patience. It is almost certain that the new Congress at Washington will present legislation that will challenge the best brains of all our hospitals. We must see to it that the smallest hospital out on the lonesome frontier and the largest hospital in the densely populated area are not forgotten. I am interested in the New Deal provided it is a "square deal" for our hospitals. This will only be possible if every one of us takes an active and positive interest in the nation's hospital welfare.*

The Joint Committee is making its plans for an unusually active year and its activities will be projected for the best interests of all real hospitals, whether members of the Association or not. Our hospitals were saved many thousands of dollars last year by the activities of this committee and it is safe to say its work will be even more valuable during 1935.

The American Hospital Association has 25 *committees staffed by nearly* 200 *of the most capable men and women from the North, East, South, and West in our Association. They are already at work for your interests and you will not be disappointed at the results of their work.*

We hope to come to the convention at St. Louis on September 30, 1935, *with a record of accomplishment that will thrill all of us and inspire us to greater activity.*

I salute you as those who because of love for suffering humanity have borne many burdens and experienced many heartaches, and will cheerfully continue, if necessary, that the health of our country may be protected. I know many of you have met the issues heroically in the past. My 1935 *New Year wish is that the experiences through which you have passed may enrich your lives and that unfalteringly you may push on in the face of difficulties, that you may have the joy that comes with overcoming. KEEP ON KEEPING ON.*

ROBERT JOLLY

E·D·I·T·O·R·I·A·L·S

Hospitals and Legislation

MEMBERS OF CONGRESS and of our state legislatures are manifesting an increasing interest in our hospitals. They are ready to show their appreciation of the great contributions hospitals are making to the alleviation of distress among the sick poor. They have been impressed with the part hospitals have played in their coöperation with Federal and state relief and welfare agencies.

Legislation materially benefiting hospitals has been enacted in Ohio, Pennsylvania, New Jersey, New York, North Dakota, Texas, and several other states. In every instance where legislation favorable to hospitals has been enacted, it has been the direct result of state and national hospital associations, through their member institutions, and their Boards of Trustees, superintendents, and staffs, directed by their legislative committees, going direct to their local members of Congress and state legislatures, presenting the hospitals' views, and securing a sympathetic hearing and assurance of support.

This year will be important from a legislative standpoint. In addition to the National Congress, sessions of legislatures will be held in 32 or more states. Hospitals must watch proposed legislation closely; every bill introduced in any way affecting hospitals must be carefully studied. The American Hospital Association will have copies of all bills introduced in Congress, and in the state and provincial legislatures, sent to the Association headquarters for study. These will be promptly referred to the different state hospital associations and legislative committees, with indicated comments and suggestions. The Legislative Committee, of which Mr. A. M. Calvin, of St. Paul, is chairman, will act as a clearing house for information on proposed legislation.

The Joint Committee of the National Hospital Associations will direct the procedures in connection with national legislation, as well as government regulations applying to hospitals.

It is most important that each hospital, through its superintendent, members of its Board and staff, and through influential friends, contact the Senators from their respective states and the Representatives from

their congressional districts in the interests of legislation on behalf of our hospitals, so far as congressional action goes.

They should present forcefully and convincingly the case of the hospitals to members of their state legislatures, so far as legislation within their respective states is concerned.

The legislator, whether national or state, listens with greatest attention to the voice of his constituents "back home." The requests of our hospitals for sound legislation, in their interests, will not fall on deaf ears, if the friends of the hospitals personally bring these requests to their representatives.

Every hospital has scores of friends who can call their lawmakers by their first name, and who can secure both an audience and a sympathetic understanding of the hospital's problems. The smallest of our hospitals has these close personal contacts.

Our lawmakers, as a rule, are friends of our hospitals. They are interested in the work they are doing. They value them for the service they are extending in their communities. If every hospital would place near the top of its educational program for the year a determined and persistent effort to educate our lawmakers in the values of our institutions to them personally and to their constituents, we could secure all the legislation necessary to the continued support of our hospitals.

Contact your Senators and Congressmen, and the members of your state legislature, in the interests of your own and all other hospitals. See them personally in their behalf, and write them frequently.

Don't ask your representative to introduce a bill, and then forget it. Help him secure its passage. Interest others with him. Give him every argument for the bill and all the information that supports it. Help your lawmakers, and you will help your hospital.

The Anti-Vivisection Campaign

THE ANTI-VIVISECTIONISTS, with ample funds at their disposal and with the support of powerful newspapers, are conducting an energetic campaign in 32 states, and are organized, as they publicly announce, to carry their fight to the finish. Model bills against vivisection will be introduced in 32 state legislatures at the coming sessions.

The enactment of these laws would be highly inimical to medical research. It would impede medical progress and hamper medical

education. To prohibit animal experimentation would destroy the processes that have yielded many discoveries that have contributed to the prolonging and saving of the lives of many millions of our fellow-beings, particularly of our children.

Animal experimentation is conducted humanely. Operations are invariably performed under an anesthetic. Medical progress cannot continue without the use of animals for diagnostic, drug standardization, as well as for research and teaching purposes. Hospitals and the scientists attached to hospital staffs are vitally interested in the continued use of animals in the work of our laboratories.

The Board of Trustees of the American Hospital Association, in session December 8, adopted the following resolution:

> WHEREAS, anti-vivisection societies, who are well organized and with ample funds at their disposal, have publicly announced that they are in a campaign to fight to the finish for passage of anti-vivisection legislation in 32 states and are having introduced in the various state legislatures laws prohibiting vivisection and in this manner destroying all opportunities for research through animal experimentation;
>
> BE IT THEREFORE RESOLVED, That the Board of Trustees of the American Hospital Association join with other organized medical bodies in memorializing each hospital to have its medical staff oppose the passage of anti-vivisection bills as a serious threat to medical progress.

Our hospitals should enlist the interest of each member of their staffs and secure the active coöperation of the members of their Boards of Trustees in combating the proposed anti-vivisection legislation.

Friends in Adversity

ADVERSITY provides the finest tests of friendship. The friend who "sticks" when prosperity departs, and the economic clouds gather, is the friend sincere. Hospitals have been encouraged by friendships like these. The constancy of such friends has enabled many hospitals, particularly the smaller institutions, to survive and continue their service for humanity.

No friends of our hospitals have been more steadfast, none more considerate, than the commercial firms who serve our hospitals. They have extended credit to the limit of their resources. They have been indulgent in all of their business relations. Many of our institutions would have been forced to close their doors without the support of their commercial friends.

There must be sentiment in business. It is not always conducted on a basis of sordid considerations. The American Hospital Association likes to feel that the generous attitude of commercial houses toward our hospitals, in furnishing supplies to enable them to continue their work, was prompted by as charitable a purpose as was the contribution made by the philanthropist, great or small, for the care of the sick. No one knows how great the sum of all this has been, as reckoned in dollars and cents. But all know how important it has been in the alleviation of distress among our indigent sick.

A great surgeon told the writer that the largest fee he ever received for a professional service was the gratitude of an old scrubwoman, whose sight he had saved through a delicate operation. When she was discharged from the hospital she waited in the corridor until he was leaving, and she took his hand and said, "Doctor, I have nothing of this world's goods with which to pay you for your great service, but I pray that the Lord will be as good to you and yours as you have been to me."

The institutional members of the American Hospital Association, as well as other hospitals, value the friendship of these firms and their representatives in the field. They appreciate the many courtesies extended them in the past, and as the economic situation brightens, they will remember in a material way those who were their friends in adversity.

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The Future of Hospital Finances

DR. THOMAS S. GATES
President of the University of Pennsylvania

THE APPARENTLY ENDLESS SUCCESSION of unforeseen social, political, and economic changes which the world has experienced during the past few years, and is continuing to experience today, has convinced all of us that there is no more impossible rôle for any man to assume than that of a prophet.

Therefore, although you have invited me to talk on "The Future of Hospital Finances," I am sure you were not actuated by a belief that I could present to you an inspired forecast of all that may transpire in that field with the passage of time, but rather by the assumption that I share with you a real interest in hospitalization and a sincere desire that ways and means of insuring the adequate financing of our voluntary hospitals may be found.

Those of us who may be found standing here tonight holding the bridge I think are singing the same tune from different standpoints. I may differ from Mr. Kingsley in putting the emphasis on another feature than he does, or from Mr. Edmonds or Mr. Johnson, but in the last analysis what I am trying to do, and what I hope you will be good enough to bear with me through, is to revitalize a program which at least offers hope.

For the assumption that I am interested in this problem there is ample justification, of course, for there are six hospitals and medical institutes affiliated either directly or indirectly with the University of Pennsylvania and this serves to make any problem relating to hospitals of particular importance to those of us who are concerned with the administration of the University.

And yet, even if I were lacking in this direct association with hospitals and their problems, it seems to me that the American Hospital Association would have a perfect right to assume that I—and every other citizen of the United States—have a vital interest in American hospitals and their welfare.

Viewed from the economic standpoint alone, the fact that the hospitals of this country collectively represent a capital investment of more than three billions of dollars and that their annual operating expenditures are about 900 million dollars, according to reliable statistics, should be sufficient to focus widespread attention upon them.

When one considers the far more important position which the hospitals in America occupy as indispensable agencies for the promotion of human welfare, however, it is inconceivable that any thoughtful man or woman

could maintain an attitude of indifference toward these institutions. For not only is everyone potentially subject to the need of hospital services but we all know that millions actually do avail themselves of these services annually.

Thus, for instance, a recent New Jersey general hospital survey, published in THE BULLETIN OF THE AMERICAN HOSPITAL ASSOCIATION, revealed that during the year of 1933 a total of 214,340 patients, or one person in every 20 of the total population of that state, entered a hospital. I do not know, of course, whether this ratio would be maintained in a similar study embracing every state, but it is interesting to note that, if it were, the total number of persons in the United States entering general hospitals last year would have reached the astounding total of nearly 6,300,000.

By revealing the magnitude of the hospital picture throughout the country such statistics as you have just heard cannot help but impress all of us with the seriousness of any general problem relating to hospitals. At the same time, however, the extent to which they indicate such a widespread public contact with hospitals should be a source of inspiration to us as we attack the problem of financing the large group of voluntary non-government, non-profit hospitals in which we are particularly interested. For certainly we are justified in assuming that no large part of the population can afford to remain entirely passive toward our efforts to solve that problem.

At present the sources of income upon which the voluntary hospitals depend for their support, as a general rule, include income from endowment funds, gifts, earnings from patients' fees, state aid, and Community Chest grants. It is recognized, of course, that there are some institutions which share in all these sources, that others share in only a few of them, and that there is a wide difference in the relative amounts which various hospitals derive from them. But since all of them exist, let us consider each one individually, both from the standpoint of its present value, as far as that is known, and from its potential value in the future, insofar as that is feasible.

In Dr. C. Rufus Rorem's splendid book, *The Public's Investment in Hospitals,* the estimated endowment capital of the hospitals registered by the American Medical Association in 1928 is given as $437,000,000, of which the voluntary hospitals had $419,000,000. Summarizing the situation in his book, however, Dr. Rorem writes:

> "Endowment capital is not an important factor in the financing of hospital service in the United States. The total number of beds fully supported by endowment income would probably not exceed 15,000 for the entire United States. Of a total of 2,604 hospitals

> organized on a non-profit basis, only 1,060 are estimated to control any endowment capital. Among this number of institutions, 125 of the more highly endowed hospitals are known to receive nearly 45 per cent of the income from the total hospital endowment. Among these 125 hospitals, only 31 control $2,000,000 or more endowment capital, or funds sufficient to endow fully as many as 67 beds each. Most hospitals in the United States do not receive endowment income in sufficient quantities materially to affect their financial policies. While it is true that certain individual hospitals, particularly some of the older ones in the metropolitan centers, depend upon endowment income to finance a high proportion of their expenditures, most of the hospitals in the United States are entirely unfamiliar with such sources of revenue."

Regardless of whether we find ourselves in general agreement with Dr. Rorem's statement that endowment capital does not constitute an important factor in the financing of hospital service in the United States, this does not, of course, prevent us from considering the possibility of increasing that endowment capital until it does become an important factor. Consideration of that possibility leads naturally to a study of gifts and earnings, the mediums through which endowment capital is most likely to be increased.

Turning again to the New Jersey General Hospital Survey covering the year 1933 we learn from the data of 19 hospitals for which comparable figures were available that the voluntary income figures of last year represented a net decrease of 38% as compared with those of 1929, the year of greatest prosperity and the one in which the income from voluntary contributions reached its peak.

A report of the Duke Endowment which refers to hospital contributions is contained in the report of the Committee on Hospital Income and Bed Occupancy submitted to your national association at an earlier session. This shows that, while contributions to 92 hospitals to which the Duke Endowment gave assistance totaled more than $1,245,000 in 1929, the donations made to 93 such hospitals in 1932 totaled slightly less than $500,000.

The contributions made by the Duke Endowment to North and South Carolina hospitals in 1929 included contributions for both capital and operating expenditures, while in 1932 the contributions were for operating expenditures only.

The same report of the Committee on Hospital Income and Bed Occupancy was authority for the statement that from 1928 to 1933 contributions to the United Hospital Fund of New York for 56 hospitals decreased 30%, and that as compared with 1929 the decrease reached 40%.

These figures may seem startling to us until we compare them with statistics showing the general trend in public giving throughout the country from 1928 to 1933 when, according to the best records available, the total of gifts and bequests dropped from approximately $178,000,000 to little more than $76,000,000—a decrease of about 57%.

In the light of such a comparison it may readily be seen that the hospitals have not occupied a unique position in the extent to which their receipt of gifts and contributions has decreased, and from this fact we may derive some comfort. At the same time we cannot escape the implication of these statistics, insofar as hospital financing is concerned, for unless we experience a sudden and favorable change in the general economic picture it is evident that contributions either as additions to the permanent endowment of our voluntary hospitals or as temporary aids to provide for emergencies may be increasingly difficult to obtain.

In turning to a consideration of the income received from patients we find also a noticeable decrease, data from various sources referred to in the report of the Committee on Hospital Income and Bed Occupancy having led that committee to the conclusion that the amount of income from patients has decreased 15% in some localities and more than 30% in others.

There is little doubt that in this field, as in the field of contributions, the decrease in income is a reflection of general economic conditions. Furthermore, assuming that the situation is such that no upward revision of the charges for hospital services can be contemplated with fairness to all concerned unless the economic picture changes, then it is evident that here too it will be difficult to increase our income within the near future.

Eight states—Connecticut, Delaware, Maine, Maryland, Michigan, Pennsylvania, Rhode Island, and Vermont—have made maintenance appropriations to voluntary hospitals, while certain other states, although they do not make grants to voluntary hospitals, have permitted their political subdivisions to pay on a per diem basis for hospital care for the indigent.

In its illuminating report your Committee on Hospital Income and Bed Occupancy already has informed you that no figures are available to show the total sum paid annually out of tax funds by various governmental bodies to the voluntary hospitals, but it has shown that while the amounts paid by governmental units in Pennsylvania, New York, and New Jersey have increased in the past few years, the amounts paid in North and South Carolina have decreased. No explanation of this varying trend in different states is offered, but it seems to me that there is marked significance in the committee's expressed opinion that the hospitals and hospital associations of the various states have not made as strenuous efforts as they should to secure support from state and local governmental sources

for the care of indigent patients. If sufficiently strenuous efforts to obtain such support have not been made, as the committee feels, we may assume that here is at least one opportunity to improve the financial position of some voluntary hospital which has not been realized to its fullest extent and which is well worthy of attention in the future.

Insofar as Community Chest grants to voluntary hospitals are concerned, I cannot offer you comparable statistics showing the trend in recent years. We all know, however, that Community Chests are maintained by the gifts of individuals and that they are influenced by economic conditions in about the same degree as other institutions dependent upon voluntary contributions. Therefore, it is safe to assume that Community Chest grants to voluntary hospitals have shown a decided decrease during the past five years and that it may be difficult to effect any marked increase in the face of present conditions.

I have now referred briefly to the five well known sources of income in which voluntary hospitals have shared and are continuing to share to some extent, but to end any discussion of hospital financing at this point would be meaningless and futile. For the fact remains that if these five sources of income were insufficient to adequately finance the voluntary hospitals of this country under the most favorable economic conditions—and they were insufficient as a general rule—then we must certainly search for new sources at a time when hospitals are being forced to care for an ever-increasing number of patients.

Fortunately we need not begin that search entirely devoid of inspiration, for there are two possible sources of relief worthy of consideration. The first is group payment for hospital care, frequently referred to as group hospitalization, and the second is Federal aid for voluntary hospitals.

Perhaps group hospitalization, which, as you know, embraces a voluntary insurance plan whereby persons of average means will be enabled better to meet the essential costs of hospital services, cannot properly be classed as a new development, for voluntary insurance plans for hospitalization have been in existence for some time.

As a rule, however, these earlier systems of hospital insurance were fostered by interests outside the hospitals and the medical profession, and this fact, probably more than any other, served to make group hospitalization the subject of considerable controversy for a time among those who felt that such a project, if instituted at all, should be conducted by the hospitals themselves as non-profit-making organizations.

It is a plan of group hospitalization conducted upon this latter principle that the American Hospital Association adopted more than a year ago, and we are informed by a recent issue of the Association BULLETIN that

an official statement of policy confirming the wisdom of the Association's plan has been issued by the American College of Surgeons. Therefore, although some difference of opinion regarding group hospitalization may still exist, it seems apparent that it is steadily gaining in favor.

Successfully applied, group hospitalization may do much to reduce the percentage of those who normally are not in a position to defray expenses incident to hospitalization and any such plan should be well worthy of serious study by those charged with the responsibility for financing the work of voluntary hospitals.

In suggesting the possibility of Federal aid as a source of income for the voluntary hospitals of this country, I realize that I am referring to something which has been traditionally contrary to the policy of the United States Government. Moreover, the recent experience which the voluntary hospitals have undergone in their efforts to clarify their status under the New Deal may be interpreted by some as an indication that no change in this traditional Federal policy can be hoped for, despite the emergency which exists.

It is well known, for instance, that although payment for the care of indigent patients in private hospitals has been made in some states, the FERA has refused consistently to permit its funds to be used by state or local public organizations for the care of indigent welfare patients in hospitals.

It is equally well known that the bill to empower the RFC to make loans to non-profit hospitals upon suitable collateral was adversely reported upon by the Committee on Banking and Currency, this adverse report being based upon the opinion that such loans would not properly come within the function of the RFC.

While on the other hand we find that in general the National Recovery Administration has considered voluntary hospitals as charitable institutions deserving of exemption from participation in the NRA requirements and codes, that they are not subject to property taxes and dividend taxes, and that the Treasury Department has granted them tax-free alcohol for scientific and charitable use, we find on the other hand that as far as the voluntary hospitals are concerned the legislative act relating to processing taxes departs from the usual exemption as regards charitable institutions and specifies that goods must be used exclusively for the relief of indigent patients.

When we consider all this—and much more that is familiar to many who are interested in voluntary hospitals—it is perhaps easily understood why a recent editorial in THE BULLETIN OF THE AMERICAN HOSPITAL ASSOCIATION contained the following paragraph:

> "At present voluntary hospitals, in Federal policy, are 'neither flesh nor fowl, nor even good red herring.' The American Hospital Association, representing the hospitals of the United States, therefore respectfully petitions the President to make a declaration of policy regarding voluntary hospitals so that they may know where they stand in the body politic."

Despite all this, however, I refuse to believe that Federal aid for voluntary hospitals lies in the realm of the impossible, and I, for one, shall be disappointed if these hospitals do not make every effort to obtain it. There is no doubt of the need for a clarification of the present situation insofar as the relations of the voluntary hospitals to various provisions of the New Deal are concerned, but it seems to me that more than this is needed, for we must think of the future as well as of the present. We know that the financial burden placed upon voluntary hospitals forced to care for indigent patients has been steadily increasing and we know there is little, if any, likelihood that this burden will decrease as time goes on.

Why, then, should we strive for any lesser objective than the actual enactment of legislation which will commit the Federal Government, both now and in the future, to bear some share of the cost incurred by voluntary hospitals in the care of indigent patients?

There can be nothing radical in such a procedure, for acceptance of a greater sense of responsibility for the welfare of its citizens and a constant strengthening of those institutions which contribute to that welfare have invariably featured the progress of enlightened governments.

The present Administration in Washington has been distinguished in particular by its intensive interest in social legislation, and certainly it is not too much to hope that it will give serious consideration to the problems of institutions which render such an invaluable service to millions of men, women, and children in this country as do the voluntary hospitals.

There is one extremely important factor which must be emphasized, however, not only in connection with attempts to obtain Federal aid but in every other activity bearing on the financing of our voluntary hospitals, and that is the necessity for unified and constant effort on the part of everyone interested.

Earlier in my remarks I said that unless we experience a sudden and favorable change in the economic picture, it is evident that contributions for our voluntary hospitals may be increasingly difficult to obtain. Likewise, I expressed the opinion that it may be difficult to effect any marked increase in the Community Chest grants, or to increase our income from patients.

Difficult as it may be, however, I do not believe it is impossible for us to obtain increased contributions to our voluntary hospitals, both directly and through Community Chests. Neither do I believe it is impossible to increase the income which we receive from patients and to obtain larger appropriations from states and other political units which contribute to our support. For we cannot lose sight of the significant fact that the results achieved in the past by those interested in obtaining support for voluntary hospitals represent only the fruits of past efforts, and the future accomplishments will be measured likewise by the intensity of the efforts put forth.

It is true that the depression has lessened the ability to give on the part of many individuals and deprived others of that ability entirely, but thanks to the growth of a social consciousness which hardships sometimes inspire to a far greater degree than does prosperity, there are probably more persons in this country today who have formed the habit of giving than ever before in our history.

Gifts publicly made to organizations can easily be tabulated. Gifts made independently to struggling relatives, neighbors, and friends throughout the length and breadth of the land never have been and never will be tabulated, and yet there is no one here who doubts that such gifts have reached a staggering total in recent years.

Can we not logically assume that those countless thousands who have been able and willing to respond to the individual appeals of the needy will not remain impassive to the appeals of charitable institutions which do so much to maintain the morale and even the very existence of those unfortunates? Is it unreasonable to assume further that there are thousands of potential givers who have not yet contributed to voluntary hospitals solely because we have neglected to present our appeal, either satisfactorily or at all? Surely there are justifiable grounds for these assumptions but they will avail us nothing unless an organized and consistent effort is made to acquaint every man and woman in the United States with the splendid public service which the voluntary hospitals render and the need for continued support of these institutions.

If the necessary machinery for the conduct of such an organized and consistent educational campaign is already in existence then let every voluntary hospital take full advantage of it. If it does not exist then it should be created as soon as possible.

Those of us who are residents of Pennsylvania well remember what occurred last November when payment of part of the legislative appropriations for state-aided hospitals, for state-aided universities and colleges, and for unemployment relief was contingent upon the passage of Amendment Number 8.

Citizens of this Commonwealth were no less aware of the need for economy than those of any other political unit, but thanks to a well organized educational campaign in which hundreds of volunteer organizations gladly participated the voters clearly recognized the importance of the issue and approved the amendment by a tremendous majority.

I am sure that everyone associated with a voluntary hospital in Pennsylvania who participated actively in that campaign for Amendment Number 8 will freely concede that it was successful only because nothing was left undone which could possibly be of service in carrying our appeal to every citizen. And in that experience there lies a lesson for all of us.

The voluntary hospitals in every section of this country have a story to tell—a story of public service unselfishly and faithfully rendered year after year in the face of handicaps which at times have become almost unbearable.

Let us see that this story is told to every thoughtful man and woman in the United States, not merely once but as often as the constantly increasing record of achievement of our voluntary hospitals justifies the addition of a new and even more glorious chapter. If we will do this there is no reason to fear for the future of hospital finances, for it will rest in the safest hands to which it could be intrusted—the hands of an American citizenry thoroughly conscious of its responsibilities and traditionally interested in preserving every great institution indispensable to the public welfare.

Disappearance of Dr. George H. Bigelow

On December 3, 1934 Dr. George H. Bigelow, director of the Massachusetts General Hospital, left his home in Milton at the usual hour in the morning to go to the hospital. He arrived at the hospital before office hours, spent a few minutes at his desk, and then went out. He later telephoned the hospital postponing his engagements there until later in the day. He was seen that morning in Framingham, his boyhood home. Many reports have come that he has been seen in Boston and other places since then. It is hard to know how much credence to place in them. None of those in contact with Dr. Bigelow before his disappearance noticed any abnormality in his conduct or processes of thought. Dr. Bigelow was Commissioner of Health of Massachusetts and resigned that office to become director of the Massachusetts General Hospital. He is a man of distinction and great ability.

The Relation of Hospital Out-Patient Service to the General Medical Practice of the Community

FROM THE POINT OF VIEW OF THE GENERAL PRACTITIONER

NATHAN B. VAN ETTEN, M.D.
New York City

THE PRIVATE PRACTITIONER and the community taxpayer would have no complaint against the free hospital dispensary if its affairs were carried on as projected in the original plans which were designed for service of the indigent and emergent sick.

The community taxpayer, crushed into silence by oppressive loads which he himself has dumbly piled upon his own back, accepts the growing incubus of shameless dole seekers as inevitable.

The private practitioner, viewing with alarm the diversion of his patients to institutional and Government care, is becoming increasingly vocal in his protests. He complains that too long he has been working for nothing but experience and declaims against lowering the quality of medical care. If he were prosperous the private practitioner would not protest. He would continue to give away his services with an inward grimace and outward tolerance, as he has done for longer than I can remember, and if and when the wheel of fortune shall turn favorably, he will forget about the depressive cycle of the 1930's and the efforts of philanthropists to compel him to accept the rôle of the practitioner of compulsory health insurance or of state medicine.

In the event of a return to comfort, 75% of private practitioners will be just as foolish as they were in the 1920's—chasing visions of the promotion of palatial institutions for housing the sick poor, forgetting that if they follow precedent they will soon be converted to the use of cheaters who occupy the beds of the poor thereby defeating the very purpose of benevolence.

The self-imposed hippocratic code under which the physician has been working with remarkable fidelity for more than 2,000 years has got him into trouble. He gives the best service that he knows and he has taught the public to value him lightly. In the hospital and dispensary he is the only person who works without pay. He is responsible for the situation in which he finds himself and he is largely responsible for the demoralization of those undeserving people who abuse the hospitality of the out-patient service because he not only sent them there but connived at their presence there.

If the often quoted figure of 500,000 clinic patients every day is an accurate one, just so many potential patients are taken away from the

private practitioner. The minimal value of one dollar a visit which has also been quoted represents a very large sum of money.

Approximately 20% of these people would be able to pay the ordinary fee of the private practitioner for the same service in the physician's office and receive a better quality of care because it would be individualized and unhurried.

Half a million people every day are learning how to get free or cheap medical care and are encouraged to do so by lax administration.

The path once learned becomes a thoroughfare.

Administration of the dispensary dole has a familiar odor, similar to that of the present relief administration carried on *by* favored political henchmen *for* favored political henchmen who much prefer to idly receive $15 a week in relief than to work for a larger sum, or relief for favored Government employees who already enjoy comfortable incomes. As illustration, a retired policeman, living on a pension with two sons who are also policemen, with a family income of more than $8,000, enjoyed free hospitalization, and at the same time drew family food tickets from the relief administration. Honest credit investigation has uncovered many such abuses of community generosity.

The physician gives generously to the institution and gets very little or nothing in return. There is very little value to the patient, to the community, or to the physician in a crowded medical clinic. One hundred and twenty patients to be cared for by four physicians in two hours means a four-minute interview for each patient. Some of the specialty clinics are almost as useless. The patient who pays nothing gets practically nothing, the physician learns very little to reward him for two hours' work and regrets the scientific futility of his efforts.

The physical set-up of the dispensary attracts the crowd from the less showy office of the private practitioner. The patient is just a numbered animal whose only interest to the physician is that of just one more case of ambulatory sickness. There are no confidential personal relations between patient and physician.

The patient believes that he is seeing an expert when usually his attendant is a young graduate trying to learn medicine. Getting something for nothing is a universal sport. Getting nothing for nothing is the usual prize.

The physician's interest in out-patient service lies in the prospect of promotion to service within the hospital and consequent prestige. He profits from the training of his senses and often repeated maneuvres in the specialty clinics and his self-esteem rises with recognition of his ability. Sometimes this recognition feeds and educates his family, but too

often he works even unto his sixty-fifth year for the acquisition of experience which never seems to gain a material value.

If the applicants for dispensary care were met at the door by an honest credit investigator probably 20% of them would turn to private practitioners if they really needed help. Non-residents of the city or district who give false addresses as their homes would be detected. In the city of New York those residents of New Jersey or of Connecticut and of up-state counties who are frequent visitors to out-patient services would be discouraged. The dispensary bummers whose favorite indoor sport is visiting one free clinic after another would seek entertainment elsewhere, and there would be more room and more time and more interest for those who really need medical attention. My doleful contentions are not designed to advocate elimination of the clinic but to eliminate the dirt that clogs the machinery, and to retuurn to the private practitioner the patient who would be most benefited by individual care.

It is impossible to value too highly the work of ardent students who, careless of financial reward, dig deeply into social and scientific problems such as those associated with the underlying causes of cardiac disease and pass on to the private practitioner and the community the results of a research which would have been difficult to find impressively anywhere else than in an out-patient service.

The clinical follow-up of patients who cannot afford long periods of treatment in a private office cannot be overvalued.

Much can be learned from a study of the operation of the clinics in the Buffalo General Hospital, and I await with great interest the results of the Rochester experiment in coördinating all of the health agencies of that city.

Studies involving credit investigation of dispensary patients are now in progress in the hospital department of the city of New York, the returns from which cannot be prematurely announced, but statistics similar to those revealed by the Morrisania study of 1933 are indicated.

A marked change in the character of the patients in the Morrisania Hospital has resulted from the investigation and from the orders issued by the commissioner of hospitals. The principal result is the change in a very busy hospital from affluent patients who demanded all sorts of special attentions, such as special nurses and special food, to patients who really deserved hospital care and who are so obviously justified in their occupancy of free beds in a tax-supported institution.

A signed affidavit of inability to pay, a follow-up of the credit investigation of all cases by nurses or social workers, the erection of a diagnostic full-time paid staff of physicians to examine and classify all new appli-

cants, would limit the number of patients, improve the service of the clinic, and be of general benefit to the private practitioner and to the community.

While I believe that the private practitioner is competent to care for nearly every type of ambulatory patient in his office I have long believed in the practicability of districting a large city or any community for the more efficient distribution of medical, dental, and nursing service. I believe that each district should support a small hospital which should house a dispensary and a district nursing station. The hospital should be equipped with competent diagnostic and treatment facilities which are too costly for private ownership. The hospital and its facilities should be open to all reputable practitioners of medicine and dentistry who live within the district and except in cases of accidents or emergent illness the services of the hospital should be limited to residents of the district only. Uniform, standardized credit investigation should be employed by all hospitals for the protection of the institution, the private practitioner, and the community.

The community is poorly served by crowded clinics.

The community is defrauded by clinic visitors who are able to pay private practitioners.

Community hospitality is abused by irresponsible non-residents.

The community suffers from division of hospital support by too many hospitals or clinics too closely located.

The community has a poor return from its investment when hospital facilities are idle because of exclusion of practitioners who are qualified to use them.

The community is poorly served by practitioners who are disinterested because they work without pay.

All of these conditions can be cured by the concerted action of physicians, hospitals, welfare organizations, health departments, and an educated public.

What Are Small Hospitals Doing to Improve Their Community Relations?

CHANNING FROTHINGHAM, M.D.
Chief of the Medical Service, Faulkner Hospital, Jamaica Plain, Mass.

THAT EACH COMMUNITY should have a hospital is now quite generally realized. By this means the physicians in that community are provided with proper equipment for the diagnosis and care of the patients who need special equipment for the proper handling of their medical problems. These hospitals are naturally supported by the community as a whole and in this way some of the cost for the medical care of an individual is distributed throughout the community.

Just how large a community or what number of inhabitants one hospital should serve has not been definitely settled. Time and experience will decide these points and presumably different localities will have different needs. Although the size of these hospitals may vary, they must be well equipped and properly organized, even if by so doing the number of them is diminished, for a hospital without proper equipment offers very little of real value to a community.

Unlike the large metropolitan hospitals these smaller community hospitals have a much higher percentage of private patients than charity cases, which makes the problem of their organization and management somewhat different from the larger charity hospitals, especially those in which the teaching of medical students is carried on.

These community hospitals should be the center of all the medical activities in the area served, which should include problems of preventive medicine and public health as well as the care of the individual patient. It is important, therefore, to have the relations between the community and the hospital on a friendly basis. One of the best ways to promote friendly relations between any two groups is to have a complete understanding of what each group is striving to accomplish. In many communities the citizens and even the trustees of the hospitals do not always have a clear idea of what the hospital should be and do. To educate the layman on these points is one of the duties of the community hospital, for there is no better way to have the public support the local hospital than to have it realize that the local hospital is a good one and doing good work for the community.

It is essential, therefore, to study the equipment and organization of these small community hospitals to see if they are coming up to the proper standards and also to see if the hospitals are articulating well with

the communities which they serve. In the course of his medical work the author has had the opportunity to observe an appreciable number of hospitals in moderate sized cities and towns throughout New England and is convinced that some of them at least are not organized to render the community as good service as might be. As the most important thing for the hospital to do to improve its community relations is to render the best of service, some time will be spent in outlining the ideal equipment and organization for a community hospital with the hope that some of these suggestions may be of benefit to existing hospitals. Thanks to the vision of its trustees and the vision, enthusiasm, and capability of its superintendent the Faulkner Hospital has already put into effect many of the ideals about to be mentioned and is striving steadily to add more to its program.

In the first place the community hospital should be a complete unit prepared to handle all types of diseases, both acute and chronic, as well as contagious and mental. Provision for obstetrics is of course included, for it is becoming more and more apparent that no matter what the medical problem is, an individual should be studied as a whole and in relation to his environment. Therefore, hospitals that are devoted to only certain medical problems must fail to be equipped to study the individual completely or else at considerable overhead expense must carry elaborate equipment which is only used to a small percentage of its capacity.

If the small community hospitals will only become complete units and if the various states will cease to practice medicine by giving up their hospitals for tuberculosis, mental diseases, etc., eventually better service to the individual will be rendered. Unfortunately most community hospitals are not at the moment complete units, but the trend is in that direction.

In addition to the erection of buildings so that all types of disease can be accommodated, the community hospital should have complete equipment so that all types of diagnostic procedure and all types of treatment can be carried out. An exception to this may be very expensive equipment for unusual diagnostic or therapeutic procedures. These unusual problems may properly be referred to the larger medical centers, but every effort should be made to keep the number of cases which have to be referred away from the community hospital to the lowest possible number.

In a community hospital there should be a properly equipped pathological laboratory which will include the carrying on of so-called clinical pathology. In this laboratory and elsewhere in the hospital a certain amount of careful study of disease should be carried on, but the more expensive type of research will undoubtedly be relegated to the larger medical centers.

The community hospital should have at least three chief divisions of its staff, namely, medical, surgical, and obstetrical, and there should be a chief of each service who is appointed from the viewpoint of his ability rather than from that of seniority. These chiefs should have offices in the hospital so that they will be more available to tackle the numerous problems which arise in any hospital from day to day.

The staff of the hospital under the guidance of these chiefs should establish rules for the care of the patients. There are of course many controversial points in regard to diagnostic procedures and treatment in the practice of medicine upon which it is not possible to make all of the physicians of a community agree. On the other hand there are certain well established facts in regard to diagnosis and treatment upon which the medical profession agrees. These can be put in writing as rules and their adoption insisted upon. In this way uniform procedure of the best type for many conditions will be established in a given hospital. Insistence upon a certain minimum amount of laboratory procedure, certain methods of examination for diagnosis, and certain forms of treatment should be maintained and incorporated into these rules. These rules should be kept available for administrative officers, nurses, dietitians, and physicians. At the Faulkner Hospital such rules have been incorporated in a loose-leaf book which is known as the Precedent Book. A copy of this is on each ward and changes are constantly made in it to improve the rules. For the keen, alert physician this Precedent Book is an assistance in his care of the patient, because it outlines treatment of the most up-to-date sort on certain diseases. It presents diets which have been worked out by the dietitian for many disease conditions so that it is easy for the physician to prescribe an appropriate diet and be sure that the patient will receive it. For the physician who is apt to be careless in the work-up of his patients the Precedent Book calls for studies which will prevent errors of omission. This book aids the nurses to grasp more readily what studies should be done on certain diseases and what is the best form of treatment and does not subject them to the confusions which the idiosyncrasies of the individual physician often produce.

These community hospitals should be opened to all the well trained and reputable physicians in the communities they serve. On the other hand the staff should so organize that certain standards must be attained before the individual physician is permitted to carry out special treatment such as important surgical procedures, etc. In this way the community will be able to know what the capabilities are of the various physicians in that community, which is an important point in view of the fact that at present there is only a beginning being made to demand certain standards of those who wish to specialize.

In addition to having the hospital equipped for the care of patients who actually enter the hospital, these community hospitals should offer services to the physicians so that clinical laboratory work, x-ray studies, electrocardiograms, metabolism studies, etc., will be available to the physicians for those patients who do not need to stay in the hospital.

The community hospital should have its training school for nurses and should establish a directory for their graduates so that the community may easily secure nursing service in the home.

In addition to its organization for the care of the individual patient the staff should plan for its own education. This calls for the arrangement of meetings at which the interesting problems are discussed and the lessons to be learned from the errors pointed out. Also prominent members of the profession should be invited to instruct the staff on the recent advances in some particular line.

Great care should be used in these community hospitals to avoid the abuse of medical charity which is so prevalent in the hospitals in our larger cities, where one frequently sees side by side in a ward patients who are of quite different financial standing receiving treatment without paying any medical fee. The community hospitals can do this by allowing patients who pay the basic ward rate to remain as the private patients of the attending physician and pay the doctor something for his services.

It is important for the citizens of the community to realize just what their hospital can do for them and also just what their physicians should do for them with the equipment provided by the community so that they will have some idea of what good medical treatment is and what they should receive for their money. This can only be accomplished by the education of the public to an understanding of what goes on in a hospital. To this end the public should make more visits to the hospital. This does not mean simply walking through the hospital to see the equipment but on these visits demonstrations should be given of just what actually is done to a patient if he comes to the hospital for diagnosis or some form of treatment. At the Faulkner Hospital demonstrations of this type are given to different groups of interested citizens from the community from time to time.

The staff of the community hospital should give the citizens of its community lectures on problems of public health, the possibilities in preventive medicine, and the early signs of diseases which should be treated early if they are to be treated successfully.

In addition to direct financial support, the citizens of a community can contribute substantially by the formation of one or more organizations which work for the hospital in one way or another to supply its needs. At the Faulkner Hospital such work is done by an aid association divided

into branches covering different localities which the hospital serves. Examples of the work this association does are the making of surgical dressings and the preparation of some of the linen used in the hospital.

That benefit to the hospital and improvement in the character of the work done in the hospital with resulting benefit to the patients will result from an active interest on the part of the citizens of the community in their hospital seems an established fact. Furthermore, this coöperation of the laymen should be rewarded by educating them in regard to medical problems.

The Board of Trustees and President

of the

American Hospital Association

Wish for every hospital an abundant prosperity during 1935, and to each member of the Association health, happiness, and all the blessings that come to a contented life.

How Should Voluntary Hospitals Be Financed?

SHERMAN C. KINGSLEY
Former Executive Secretary, Welfare Federation of Philadelphia

THERE IS A CLASSIC PICTURE of a future city whose central feature is a tree of life and whose leaves are for the healing of the nations. I do not know the interpretation, but I do know that ever since man recorded his thoughts and actions the art of healing has been practiced and that for ages sound health has been a supreme human desire.

The hospital came into existence as an instrument to help fulfil a fundamental need and has progressively grown in the favor of men and has become a fixed star in the firmament of approved services to mankind. We are indebted to the vision and generosity of men and women of past generations and ages for our hospitals. It is our problem and responsibility to further their usefulness and to establish dependable avenues of support. Necessity compels action. Every community in the United States faces this urgent problem.

Volunteer hospitals have depended upon three major sources of income for their life. These are, first, voluntary giving including endowment; second, payments by patients called earnings; and third, taxes. Volunteer hospitals, of course, get their building and equipment through individual giving, by request, through the community, or by groups. This equipment in our country now represents hundreds of millions of dollars. Volunteer giving and income from endowments yield approximately half of the support. Earnings take care of from one-third to a half, and taxes or deficits represent the rest. Practically every such hospital represents a perpetual effort for existence. In isolated cases endowments afford an adequate or fairly secure support, but they are exceptions. In normal times we have pulled through except where there has been a grossly ill-advised or badly managed effort and where ambition to maintain a hospital has not taken due regard of community needs. The urgency of the times has put a new emphasis on the question of need, number, and efficiency of hospital units. In the recent past we have worked against a background of from one to three million unemployed. For three or four years the number has been variously estimated at from nine to 13 million. There now seems to be an expectation that, even with recovery accomplished, there will be regularly a larger number of unemployed, again estimated at four or six millions. This certainly will further complicate the problem of hospitalization.

Hospitals have come into existence over a number of routes, religious denominations, fraternal orders, and nationality groups, and to further theories of medicine, individual ambition, and specialized needs.

Paralleling this increase of volunteer hospitals, we have witnessed a like growth in the number and size of Government hospitals—national, state, and local. These, of course, are entirely tax-supported. This does not mean that tax support is certain and adequate nor that Government hospitals can or do exist without citizen interest, devotion, and concern. It does mean greater certainty of support. Nothing, they say, is inevitable but death and taxes. A better way to put it, since we are discussing health, would be death *or* taxes.

When it comes to the volunteer hospitals, if what we have said about their motivation, namely, religious denominations, fraternal orders, nationality groups, schools of medical thought, and individual ambition, is correct, there is this to be said—these special urges and not community needs necessarily have been dominant in starting many hospitals. For instance, there is no denominational disease, Baptist, Presbyterian, Episcopal, Lutheran, Dunkard, or Universalist. Medicine, not theology, is practiced in a hospital. Patients are not selected on the basis of religious belief but on account of physical condition. Reliance for effective treatment and service must be on proper diagnosis, treatment, and physical care, and not on dogma or creed. Likewise there are no nationality or fraternal diseases as such. Hospitals created in response to schools of medical thought and individual ambition may be sound if based upon a theory of medicine or a school of thought which has a universal application or end. Whatever the motive for the inception of the individual hospital, they must all meet the test of service and efficiency. They will stand or fall according as they become useful to the community. It is true that denominational, fraternal, and nationality groups open into specific avenues of support and these persist in accordance with the vitality of the parent group, but they will finally win or lose according as they meet health needs and service to the community and not be serving creeds, race, or individual ambition.

How then should voluntary hospitals be financed? *First,* let me say frankly, *there are hospitals that should not be financed.* There are hospitals that should merge with others or go out of existence. There are hospitals that are ill-conceived and badly managed. Each hospital should be able to reveal its operating costs, service figures, number of beds, percentage of occupancy, the value of its plant, endowment, and its avenues of support. Thus the public can know the number and quality of hospitals in the community. This will afford a sound basis for judging whether it has too many or too few and will leave a clear field for judgment on the duty of support.

Every large community should have the benefit of a hospital council and the aid of boards of health and other public-spirited community

groups whose interest and contacts give them a knowledge of the health and hospital problem. In each case where there is a question of the usefulness to the community of a hospital, the help of such groups should be sought in determining the question. A suspicion that there are too many or that they are inefficient or inadequate affords an insuperable alibi on the question of volunteer support.

Second, disease prevention and health promotion activities should be developed. There is still much unnecessary hospitalization, notably in the field of accidents, unnecessary occupational diseases, and lack of reasonable care of health. One hospital in Philadelphia dealt with 18,000 accident cases in a single year. The whole field of accident prevention is a job for the public. Of course, many victims of accidents can pay the immediate cost, but the whole question of reducing accidents is a public job.

Every hospital of 100 beds or more affords thousands of days' inpatient care to persons whose sickness could have been prevented by physicians or health agencies if taken in time. Out-patient departments are the most promising present resource in this field. Their development and perfection is the most promising step in sight, and therefore supporters of hospitals and health services should increasingly advocate and back this service. This procedure is negative in the sense that it is not dramatic—no flare of ambulances and flowers, the anxiety and concern of neighbors and friends—none of the attendant horror and concern that go with accidents and acute illness. I heard one hospital manager say that he believed that as much money was spent on flowers as is spent for the patient's care in the hospital.

Third, the voluntary support.—The whole gamut of devices has been used—gifts, raffles, lotteries, card parties, lawn fêtes, horse shows, rodeos, charity balls, commissions, melting pots, theatrical benefits; appeals—denominational, fraternal, racial; schemes—sound, bogus, shady, criminal; everything imaginable has been tried because the cause is so good.

Red figures have a logic of their own. Hospitals are dealing with a red figure problem and the depression is big enough to be an aid to public thinking. It ought to think. It must pay.

Self-help efforts.—Combinations: We will assume that where combinations can and should be effected, this will be done.

Earnings: There is not much hope of any greatly increased earnings from the patients themselves. Some hospitals, however, can better their position without injustice or hardship to patients by increasing their earnings. This is usually brought about, if not already in vogue, through the

services of a first class credit worker or workers. If a hospital has no credit worker, it can probably increase self-help by securing one.

Reduced expenditures: To the extent that hospitals can lessen their in-patient days through out-patient services they will save money. It is further assumed that all expenses have been or will be given the most careful study and the public be given all possible benefit of legitimate economies.

Purchasing: In practically every community in the United States money can be saved through the development of a wisely conducted joint purchasing scheme. This is not a matter for hurried achievement but it does hold possibilities that should not be overlooked.

Voluntary giving.—The Community Chest or Federation plan of raising money has proved to be the most effective so far devised. In communities where they exist—over 400 of them in the United States—more money is raised than was raised by the individual appeals of the agencies which are now members of the respective federations. The hospitals of the Welfare Federation of Philadelphia have received much more through the Federation than they received when they made their individual appeals. The Federation movement has striven to show in an aggregate figure the needs of its agencies from the voluntary givers of the community. This figure is based on the accomplishment of the organizations in the past and in some measure reflects also their hope for the future. The agencies usually ask much more than the Federation is able to secure, but this is in reality nothing new. They always did desire much more than they got and, as stated before, they have got much more through the Federation and Community Chest than they secured in the aggregate by individual appeals. The depression of the past four years has greatly increased the problem. Federations and Chests are redoubling their efforts, guided and helped by their past experiences and strengthened by conviction gained through a more adequate and convincing knowledge of community needs. They need the utmost devotion and help from every member hospital and need it this year as never before.

Hospitals have one outstanding advantage. The hospital is the best understood, most universally accepted and used, and the best loved institution in the community. Nobody knows the day or hour when he, his family, or his friends may need it. Every hour of the day somebody who has started for a dinner, a picnic, or the theater goes to the hospital instead. Thanks to the community that has such places, the victim of an accident or disease does not have to wait for it to be built or equipped; it is there with the bed made, x-rays and anesthetics ready, a doctor and a nurse on hand.

The group hospitalization plan.—Here is an idea with real possibilities. The essentials of the plan can be briefly stated. Persons with a job and below 60 or some approximate age pay a membership of eight or ten dollars a year. Such payment entitles them to 20 or 30 days' care in semi-private accommodations in a hospital, with its accompanying care and treatment. The person goes to the hospital of his choice, and with the advice of his own physician. He may receive on one or subsequent visits the full complement of days' care in the year of his membership. Thus for about 75 cents a month his hospitalization is provided for. Instead of being an indefinite expense and an unknown quantity, he has this assured. This plan does or should include some concession for the worker's family such as a reduction in rates.

There are upwards of 30 million persons eligible for such a plan in the United States and tens and hundreds of thousands of them in each community. This affords a plan which, if carried out to the full, can become a great factor in the support of hospitals, and perhaps it can meet their total needs for other than the indigent or unemployed in the community.

It seems to me that hospitals individually or through their associations should give this their most serious consideration. I believe it will benefit the physicians as well as the hospitals. Of course, there are cases where more than the indicated number of days of hospital care will be needed, but for the whole group of salary and wage-earners I believe this plan is one of great promise, and it should have whole-hearted consideration by hospitals and physicians.

Taxes.—It seems probable that the unemployed, indigent, and victims of chronic disease must be cared for through taxation, old age insurance, and tax-supported agencies. I believe that such tax support should come from local communities and the state rather than from the Federal Government. I do not know of any argument that would intrinsically proscribe Federal aid to hospitals. I know that strong pressure has been made for Federal help. However, the hospital is a highly organized institution. To be sure, it has its hotel aspects, but it deals with the intricate problem of health. It depends upon diagnosis, which requires highly trained human skill as well as the use of devices and inventions that are almost human in their intricacy, precision, and revelation. Care, cure, and prevention, which are implied in the work of hospitals, it would seem, could be carried on more satisfactorily by communities and states than by a far-flung machinery from Washington.

Hospitals answer a fundamental human need and are here to stay.

A means of dependable support must be found. Hospitals cannot operate in red figures indefinitely.

Each hospital is in duty bound to justify its continued existence by efficient administration and maintenance of approved standards, and to prove its support by the quality, amount, and expense of its service.

Preventive work should be stressed through out-patient departments and kindred agencies to the end of better health and to reduce the need of hospital care.

Much hospitalization is called for because of needless and preventable accidents. The public should have the facts and prevent accidents as well as reduce occupational and other preventable disease.

Unneeded, useless, and inefficient hospitals should merge or go out of business. Hospital councils and kindred bodies should be available to aid in a just determination of such cases.

Federations and Community Chests are doing their best to help member hospitals. They need the help of member agencies as never before.

The group hospitalization plan affords a new avenue of support. Wage and salary workers can secure, at a modest sum, 20 to 30 days' hospitalization annually. This plan has a background of some 30 million persons as prospects. It may become a large factor, perhaps complete, in the support of volunteer hospitals.

Finally, state and local taxes must become the reliance of the unemployed, the chronic sick, and the aged.

Tri-State Hospital Meeting

Meeting with the Illinois, Indiana, and Wisconsin associations at the Hotel Sherman, Chicago, May 1, 2, and 3, will be several other allied groups, probably including the nurses, dietitians, record librarians, hospital social workers, and anesthetists, also holding sectional meetings.

The Ohio Hospital Association

April 2, 3, and 4 have been definitely designated for the holding of the annual convention of the Ohio Hospital Association. The following affiliated organizations will meet with the Ohio group at that time:

Ohio Dietetic Association
Ohio Association of Record Librarians
Ohio Association of Nurse Anesthetists
Ohio Obstetrical Society

The convention will be held in Columbus, Ohio, with headquarters at the Deshler Wallick Hotel.

Some Social and Personal Problems of Surgical Patients

IDA M. CANNON
Chief of Social Service, Massachusetts General Hospital

THERE IS GENERAL AGREEMENT among medical social workers, I believe, that hospital surgeons usually look to social service for two specific types of service, namely, facilitating the early discharge of patients—familiarly known as "clearing the wards"—and arranging for the return of patients for determining "end-results." These two phases of an actively functioning surgical service are recognized by all as important to efficiency. I should like to bring forward for consideration some of the no less important but less frequently discussed aspects of surgery with which social workers are concerned, and to raise some questions that, it seems to me, are of significance to both the surgeons and the social workers and to the patient most of all.

You will remember the story of the blind men of Burmah and the elephant—how one felt of his leg and thought it was a tree, one of his tail and thought it was a rope, and one of his side and thought it was a wall. I do not wish to push this analogy too far but it does suggest the possibility of too limited interpretation that may be made by any one of us who is involved in the widely diversified specialization demanding concentrated focus of attention that we recognize as characteristic of highly organized medicine. We, as medical social workers, whose professional function is concentrated on the patient as a person and in his human relationships, wish that it might be clearer to the surgeons that our interest includes not only the satisfactory and prompt discharge of the patient, and the surgical end-result, but more especially what is happening during the time between these two episodes and also after the surgical end-results are dismissed from attention. We believe that the patient would benefit from a more satisfactory coöperation between surgery and social service in this area.

The relation of character and personality to the experience of sickness has always been a subject of major interest to social workers. We have considered that our service was primarily concerned with "character under adversity," and that sickness, and pain, and facing of death and prolonged crippling disease brought special tests of character. Possibly we have been thinking of personality as consistently preserved while sometimes unhappily and sometimes heroically revealed in the course of the experience of sickness. But we are asking if sickness is not one of the great molders of character, both for good and ill, and if we may not suitably give more attention to understanding this factor in sickness. I have in mind a ques-

tion raised by Dr. Nathaniel Allison concerning the effect of prolonged and repeated hospitalization and surgical procedure for some five or six young girls in late adolescence, who have long medical and social records during the several years that they were treated for tuberculosis of the hip or congenital dislocation of the hip. All of these patients showed marked character changes, manifested by great irritability, self-centeredness, and increasing difficulty in human relations when they were put to the test. Dr. Allison raised the question, I do not know how seriously, as to whether there were physiological changes attendant on repeated surgical experience. And we as social workers voiced the consideration of the effect of prolonged dependency and what we call, but do not fully understand from the psychological point of view, a "hospitalized" attitude. I remember that one of these girls came into the clinic some time after she had been considered in good condition, with complaints of typical pains that she had previously experienced. The doctor in careful examination declared there was no physical pathology. We recognized that she either consciously or possibly unconsciously sought the security of the institution and the attention that she needed to escape an intolerable feeling of inadequacy.

This is all familiar to doctors and nurses as well as social workers. Because it has such great significance from the point of view of the human relations of the patient and extends beyond the period of the hospitalization, it is of special concern to social workers. But since we are all theoretically interested in the restoration of patients to what we call their "normal place in the community," we would like to suggest that the question of the psycho-social aspects of the surgical patient may well be more thoughtfully studied.

Some six years ago, a 36-year-old painter was admitted to the surgical ward of a general hospital for study and possible operation. He had a colitis of long standing. An iliostomy was performed, and a special belt was supplied. A high grade of surgical service was rendered this patient, both in the wards and out-patient clinics over a period of several years. On the patient's very insistent urging, following his desperate threats of suicide and after very thoughtful surgical consultation, the iliostomy was successfully closed. I am sure that this case is among those recorded as having excellent surgical end-results. But let us look at another side of this question of end-results. From the point of view of social service we have a different story. Mr. O'Neil was six years ago the self-sufficient head of his family that consisted of a wife and an eight-year-old son. He was a skilled painter, well paid. During the period when a carefully prepared diet was a part of the treatment the intelligent, devoted wife co-

operated well in the plan for his care. His illness had begun to interfere with his steady work when he came to the hospital. Then the doctors stated that he should give up painting because the stretching, which was a necessary process in his work, was bad for his physical condition. The details of the social case history which would have to be assembled not only from the record of the social service department but also from a relief society, visiting nurse, and children's agency and the testimony of the minister of the church who struggled with this patient in trying to help him through his difficulties. Now after six years we find a family torn by conflict, a father drinking, gambling, borrowing money from friends with no chance of repaying, willing to be dependent on public aid, physical abuse of his wife, and the wife considering the breaking up of the family because of the bad influence of the father on the 14-year-old boy. The retort may be that this is a failure of social service. Possibly so. Surely the general unemployment situation had its part in this case, for we at first had to deal with a man eager to work, in spite of his disability. The social worker involved in this case believes that if illness had not come to this patient he would still be the adequate head of the family. She asks, were we too ready to follow the doctor's advice in relieving this patient of responsibility, would we have had better end-results if he had persisted in painting, struggled along with inadequate diet? What would this have done to the surgical end-results? So marked have been the character changes in this patient that a neuro-psychiatric examination was arranged to determine if it were a psychosis. The psychiatrist thought not. We may well ask if psychiatry with its deeper insight into personality may not have had something to contribute to the surgical and social treatment of such a patient at an earlier stage.

We at the Massachusetts General Hospital have had some significant experiences with diabetic patients who have had to have operations for gangrene of the extremities. I say operations, for it is frequently a matter of multiple operations, not single ones. And it is the repeated experiences that seem to give rise to the psychological situations that I wish to bring to your attention. I have in mind a 70-year-old man whom we have known for four years as a diabetic. He was a skillful iron-worker who took great pride in the fact that he had helped to make the iron beds for one of our big hospitals. He gave the impression of being immaculate in his personal habits and was very careful of his appearance.

He had earned good wages and had some savings when sickness overtook him. He seemed a friendly, gracious person and lived with his wife in a comfortable tenement. Then the long struggle with diabetes came. He and his wife tried to follow orders carefully, and he seemed

to be adjusting himself to his disease. Then came evidence of gangrene of the right foot. Amputation was necessary to the knee. This proved to be a great psychic shock to the patient, so much so that he refused to see his friends with whom he had been on good terms. It was assumed that this was a temporary phase in his experience. Then gangrene appeared in the left foot and it, too, had to be amputated. This only served to increase his feeling of being a different person, and made him more egocentric, more determined not to be seen by his former associates. The house had a porch where his wife tried to have him sit in a wheel chair. But he persistently refused. This patient's diabetes seems to be under control. The surgical end-results are, I presume, recorded as good. Now, three years after the third operation, and the removal of the patient to a suburb some distance away, he is gradually going out in his wheel chair. His spiritual struggle is not over by any means.

Then again there is the 60-year-old American man, who lived with his wife and grown son and daughter, an obviously dominant head of the family which he supported by his work in a greenhouse. It was a distressing experience to see what seemed to be a gradual but steady degeneration of character in this man as he had to go through four successive operations, first on the big toe of the right foot, then another toe, then the leg, and then the left leg. The after care of this patient presented serious problems. His inability to carry on as head of his family economically was difficult for him to accept. His impulse to dominate took the form of such disagreeable and irritable actions on his part that the family finally decided that they could endure it no longer and he was sent to a nursing home where he has remained for two years. The nurses find him a difficult patient but are able to deal with him better than his family. They find it easier to maintain evidence of family loyalties by the less frequent contacts. The expense of his care at the nursing home seems to them well worth the necessary sacrifice.

In sharp contrast to these patients is Lucy Hogan, who has so far triumphed over surgical experience of 14 admissions over a period of 25 years of Raynaud's disease and eight amputations for gangrene of the lower extremities, that she meets each day with a gaiety of spirit that is an inspiration to all of us who have the privilege of knowing her. She would say that it is her religion that makes it possible for her to go on happily. The story of her struggle to attain this attitude is not recorded.

We have had associated with our department for the past 16 months a clergyman who came to us as supervisor of theological students who come to the hospital through the interest of the Council on Clinical Experience for Theological Students, an organization in which Dr. Richard Cabot has

long been interested. The purpose of the council is to give these students an opportunity to learn something of what sickness and suffering of body and mind mean to the patient and incidentally to learn something of the ways of hospitals and of doctors. One of our leading surgeons who had become impressed with the possibility of the clergyman's bringing a special insight to the needs of the surgical patient asked Mr. Dicks to see a series of patients who had had colostomies and to answer the question as to why patients reacted so differently to the experience. This study is still in process, but out of the 26 patients so far considered there is evidence of the importance of taking into account the personality of the patient who is to have so radical a change in his way of life, and of developing better methods of serving the emotional and spiritual needs of these patients. We know that these patients often think of themselves as "unclean," as unfit for social relationships, and it is suggested that the psychic trauma has not been so skillfully treated as the physical condition. We have heard today of the elaborate care that is being given to safely and effectively save the patient physical pain. Would that we had so great skill in so far controlling the psychic pain that it need not be a destructive experience.

My purpose in bringing before you this question of the psychological factor in the surgical patient is not that I fail to realize that every surgeon and every nurse of experience knows that the personality of his patient must be reckoned with. I assume that in his private practice the surgeon finds it one of his major problems. It is forced to the forefront of his attention, for he must deal not only with the "whole patient" but often with the whole family as well. This continuity and unity of experience of "the surgeon" and the patient is not so consistently held by any one person in a big, busy, complex hospital, with its quick turnover. Is not this consistency of consideration important enough for us to work seriously toward securing a more unified service through better coöperation, or better integration of all our skills?

We have at this hospital an illustration of the sort of coöperation I have in mind. A few weeks ago, the head of our plastic clinic referred to us one of his patients who had come to the clinic intoxicated. "What kind of person is she?" He, with the imagination that, I presume, is a necessary part of the plastic surgeon's equipment, suspected that he was not seeing the real person at that clinic visit. He also knew that we are interested in the stream of the patient's life and not in any one period of his contact in ward or clinic. This 36-year-old Irish girl had had an auto accident last spring and suffered a serious facial injury. The clinic visit was the first following the first plastic operation. Briefly, our social study

revealed a girl who for some 15 years had held an increasingly responsible clerical job where she had personal contact with many people. Her family had a history of alcoholism, although she had never succumbed. This serious facial injury, the loss of not only her work but the responsible position it entailed, proved too much for her. When the facts of the case were known we all combined, patient, surgeon, priest, medical social worker, to work through to restoration of this patient not only physically but economically and socially. We are convinced that the prognosis on all scores is good. I believe the patient will be more of a person when she is discharged from care.

We are hearing increasingly these days of the introduction of psychiatry into the general hospital, the purpose of which is better understanding not only of functional disease but also of the functional factor so often present in organic disease. The contribution of psychiatry to medicine is only beginning to be appreciated, or at least so it seems to many of us social workers who are turning to psychiatry for deeper insight into human motives and the conflicting forces in personality. May not psychiatry have something to give to a better understanding of the patient in the surgical ward where we see at work the forces of fear and loneliness and bitterness which Dr. Cabot has called retrogressions of spiritual growth. I believe that both psychiatry and religion should have something to contribute to the study and aid of the types of problems that I have suggested.

It is the psychic shock in surgical experience that would seem to need exploration. At least may we not become more skillful in preparing the patient who for the first time faces the startling experience in the hospital ward and operating room which are to us so very familiar and congenial. Surgeons often state that their skill is to give nature freedom to do her mysterious work of repair. The patient must of course be the one who must finally struggle through the personal problems that I have discussed. But may we not, collectively, attain finer methods of freeing the patient to make more satisfactory repair of the psychic wound? May we look forward to the time when evaluation of end-results will cover not only the physical findings and the functional capacity such as is noted in the end-results of fracture cases but will also seriously consider the capacity of the patient to carry on in his human relations? I realize that personality and character offer probably the greatest variable, but this only serves to emphasize the necessity for its more earnest consideration.

The Use of Private Agencies in Public Functions

REVEREND JOHN O'GRADY
National Catholic Welfare Conference, Washington, D. C.

Since 1878 the use of private agencies for public service in the field of social work has been a subject of very keen and, at times, very bitter controversy. Those of you who remember the New York experience of 1914 can very well recall the bitterness that was associated with that debate.

The type of social work about which the most acute controversy raged has been the field of child welfare. Private agencies have not been used

> **The hospital represents a very important contribution of various groups to public service. It represents a spirit of sympathy and understanding that represents an important gap in community life. The ordinary hospital is not a mere business enterprise. It represents a spirit of sacrifice and of devotion that mean so much in the life of a community. American communities have shown that they want to encourage the devotion that finds expression in their private hospitals. They have shown it by their support of them and their kindly and sympathetic interest in them.**

on a large scale for the administration of relief to families in their own homes. Between 1880 and 1900 the practice of administering public relief through private agencies developed in a number of places. During these two decades there was a notable reaction against public relief. Where public relief was retained it was felt that it could be administered more efficiently through private agencies.

In its historical development child care in the United States has differed vastly from family relief. The children's aid movement stressed the difficulty and frequently the impossibility of changing the life habits of adults. It felt that its great hope was to get the children at an early age and place them in good American homes. It wanted to mold the lives of children according to a definite pattern. It believed that in this way they could be brought up according to good American standards.

The leaders of the immigrants were not satisfied with the philosophy and methods of the children's aid movement. They wanted to bring

their children up according to their own ideals and the teaching of their own religious faith. Since the children's aid societies were receiving public assistance for their program of child care immigrant leaders felt that they should receive the same consideration for their program.

In a number of places in which the immigrants developed strong leadership they were able to secure recognition of their point of view. A point well worth remarking is that the immigrants received strong support from many Protestant leaders, notably those of the Episcopal Church.

From the viewpoint of the leaders of the new races public child-caring agencies and institutions were in the same category as the work of the children's aid societies. Until 1902 the State Board of Minor Wards of Massachusetts failed to reckon with the religious faith of Catholic children just as much as any of the children's aid societies. In view of this situation one can understand why it was that persons interested in the religious welfare of children struggled so hard to have their agencies used by states and local communities in child care. Community leaders felt that it was more economical to use existing agencies and institutions rather than develop their own mechanisms. They also felt that it was good policy to recognize the viewpoints and philosophy of the various groups. By fostering group programs, moreover, they were aiding in the development of strong educational forces in the community. Therefore it is that the use of private agencies in child care has become a tradition in most American communities.

Until recently there has been comparatively little controversy about the use of private hospitals for the care of the indigent sick in local communities. Where private hospitals have developed the necessary equipment, where they have been articulate and shown a willingness to participate in community progress, communities have been willing to avail themselves of their service. Local governments have been slow in developing public hospital programs. When they began to recognize the need of hospital care outside of the poor houses, they found that private hospitals were fairly well developed and they decided that it was more desirable to use the existing facilities rather than duplicate them.

Private hospitals in the United States developed very rapidly after the Civil War. The experience of the War gave the medical profession a new appreciation of the value of organized medical and nursing care. When the members of the Army Medical Service returned to their own communities they assumed the leadership in establishing hospitals. Many times they associated with them those who had aided them in establishing a systematic nursing service in the Army hospitals.

The large development of Catholic hospitals in the two decades following the Civil War was due to the work of the Sisters during the War.

They acquired a new vision of the importance and possibilities of organized medical and nursing service. The members of the medical profession that had been associated with them developed a very great appreciation of their worth. Therefore it is that our communities received so many invitations to open new hospitals during the decades immediately after the Civil War.

In a very large number of cities the hospital represents a real community enterprise. The entire city participates in its establishment. Every citizen feels that he is part of it. It has been his comforter in sorrow and in death. He appreciates it not only because of what it has done for him but because of the works of charity it has done for others. One can therefore understand why it is that private hospitals have become such an essential part of community programs. When cities wanted to provide for the indigent sick it was only quite natural that they should have turned to private hospitals. In many instances the private hospitals for years had carried the entire load of public hospital service. As the load became heavier citizens interested in the hospitals suggested to city officials the desirability of a small corporation. The program was not worked out systematically. There was no discussion of rates that equaled the cost of service. The hospitals received with thanks what the city fathers were willing to offer them.

The hospital represents a very important contribution of various groups to public service. It represents a spirit of sympathy and understanding that represents an important gap in community life. The ordinary hospital is not a mere business enterprise. It represents a spirit of sacrifice and of devotion that means so much in the life of a community. American communities have shown that they want to encourage the devotion that finds expression in their private hospitals. They have shown it by their support of them and their kindly and sympathetic interest in them.

In this period of transition do we want to sacrifice the finest traditions of American communities because they do not conform to a stereotyped pattern of government? Do we not want rather to conserve what is best in our heritage and add what is needed to meet our present problems? The private hospitals represent a fairly well developed program. There is no good reason why Government should duplicate the program insofar as it is adequate. Such a course on the part of Government would discourage all private enterprise. It would deprive private projects of that security that is so necessary for them. From the standpoint of social work it would mean that the ultimate would be sought in the state..

It is quite clear that there are gaps in our hospital organization that can be met only by the development of public hospitals. There are

whole areas in the United States that are utterly lacking in hospital facilities. Even in our large cities there is a great dearth of hospital facilities for chronic and convalescent care.

It would probably cost from a billion and a half to two billion dollars to build public hospitals to render the service that private hospitals are now rendering to the public. Are we justified in expending such a large sum of money while we have an adequate number of beds available in private hospitals? I am sure that when the problem is interpreted to them properly the citizens will not permit officials to build hospitals for a service that can be given just as economically and much more efficiently by private hospitals.

The American Hospital Association and the 1934 Mobilization for Human Needs

The American Hospital Association was one of the original national welfare organizations which in 1932 joined in financing and in promoting on a national scope the welfare and relief mobilization. The Association has been very much interested and been active in lending its support to and in promoting the success of this great national movement.

The direction of the national activities has been under a committee of which Mr. Newton D. Baker was chairman and the following were members: Mrs. Franklin D. Roosevelt, chairman National Women's Committee, Allen T. Burns, executive director, and Albert D. Lasker, Alfred E. Smith, George E. Vincent, and Ray Lyman Wilbur, vice-chairmen.

The campaign of the 1934 Mobilization for Human Needs began October 21 and ended November 11.

We are in receipt of the following communication from Mr. Newton D. Baker, chairman of the 1934 committee:

December 10, 1934

Dr. Bert W. Caldwell, Exec. Sec.
American Hospital Assn.
18 *East Division St.*
Chicago, Ill.

My dear Dr. Caldwell:

Another Mobilization has just ended. As one of the thirty-five national agencies coöperating in the Mobilization I think you may like to know that social work this year received more space in newspapers and magazines than it has in previous years during the same period.

Our effort to interpret to the American public the human needs which cannot be provided for without their understanding and generosity represents, I think you will agree, a goal worthy of the struggle.

May I thank you, therefore, in behalf of the Mobilization for adding your strength to ours in this united front we term the "Mobilization for Human Needs."

Sincerely,

NEWTON D. BAKER
Chairman
1934 Mobilization for Human Needs

THE RIGHT REVEREND
MONSIGNOR MAURICE F. GRIFFIN
TRUSTEE, AMERICAN HOSPITAL ASSOCIATION

For Merit

▲ ▲ ▲

HIS HOLINESS, upon the nomination of the Most Reverend Joseph Schrembs, Bishop of Cleveland, has appointed Right Reverend Maurice F. Griffin to the dignity of Domestic Prelate. The ceremony of investiture took place on Sunday, December 23, in St. John's Cathedral, Cleveland.

As man and priest, wise in all those humanities that make for a happier and more abundant life for his fellowmen, loved and esteemed by everyone, of whatever religious denomination, Monsignor Griffin has walked his ways with dignity. His presence has brought good cheer and a confidence in the righteousness of things ordained. His smile is a benediction.

As distinguished as his services have been to his church, his contribution to hospital service everywhere, to our institutions as well as to the patients in their wards, would fully warrant the bestowal of this high honor upon Monsignor Griffin. He has always been a leader in the hospital field. He has stood for every worthwhile development that has made hospitals better. He has been a wise counselor, gifted with a thorough understanding and a broad vision of hospital activities. His influence has stabilized hospital effort and promoted harmony of policy and purpose.

Monsignor Griffin, in point of service, is the oldest trustee of the American Hospital Association. He has been Vice-President of the Catholic Hospital Association since 1929. For more than a generation his quiet, efficient service has constituted one of the most valuable assets of the hospital field on this continent.

Hospital Association Activities Throughout the Dominion*

G. Harvey Agnew, M.D.
Secretary, Department of Hospital Service, Canadian Medical Association, Toronto

It is surprising what conventions mean to hospitals, particularly to the small hospitals. Everyone who attends gets so much out of the conventions, for the program is planned to meet the needs of all. It is a real breath from outside to associate with those who have the same problems, and it is stimulating to hear these problems discussed in large gatherings. It is a matter of regret that more hospital people cannot be present at these valuable meetings. It would be a great thing for hospitals in this province if not only every superintendent, but an average of say five trustees from each hospital, each medical staff, the president and secretary, as well as a large delegation of supervisors, dietitians, technicians, members of women's aids, and others could be present. Another definite development is a greater spirit of camaraderie. Workers getting acquainted with each other have opportunities of meeting on a common ground and discussing common problems. It was my privilege to be present at the initial meeting of the Hospital Association of Nova Scotia and Prince Edward Island. At that time these good people were all strangers to each other, but there has developed the greatest spirit of friendliness. Hospital people also find it so much easier to correspond with each other or to actually visit if an acquaintance has already been made.

The keynote of practically all conventions has been economies, especially these last few years when the depression has played havoc with our finances. This subject is of most pressing concern to all hospitals and it is the one most frequently discussed at round table conferences. The public hospitals of Canada, exclusive of mental hospitals, expended in 1932 over 43 million dollars, of which approximately four million was spent by the British Columbia hospitals. There is no question that economies have been instituted and developed until it is extremely doubtful if any more than very minor changes could now be effected in the average hospital without impairing efficiency. I think hospitals have done their bit—running expenses have been pared to the bone—as Dr. George F. Stephens of the Winnipeg General Hospital says, "through the periosteum"—and many will have to augment their present facilities if they are to continue to give the public the service which is anticipated and is expected of them.

*An address before the British Columbia Hospitals Association, Victoria.

There is one thing the public sooner or later must realize. We have whittled hospital costs to the limit. Hospital costs cannot stay there. Neglected repairs and postponed replacements must be made. Nurses and others cannot go on working for next to nothing; nurses are still keeping pre-Victorian hours, 12 hours a day, and working Sundays and holidays when other people are resting; this cannot go on and if we are even to maintain our present efficiency we shall soon have to face higher costs. The ratio of free work is steadily rising and, unless some better system is devised for reimbursing the hospital for this work, we shall either have to close up or raise private rates. Neither policy is desired, but how long would a retailer stay in business who gave away two pianos with every one he sold?

Legislative problems have occupied the attention of most of the associations and all have active committees on this subject. In your province you have been successful in having your grants restored; that was a signal recognition of the validity of the claims of our hospitals for proper recompense for their assumption of this burden of the indigent patient. Other provinces have been sympathetic, but have not felt financially able to give the hospitals further aid. In Ontario the drastic economy measures being initiated by the Hepburn Government lead the hospitals in that province to be very apprehensive concerning the immediate future.

In this connection it is interesting to note that the long standing difference of opinion between municipalities and hospitals has been ironed out in a number of details in the province of Saskatchewan. This has been accomplished by the interchange of delegates to each other's conventions, a procedure which has proved exceedingly educational and beneficial.

Compensation Board arrangements have been reviewed and improved in several provinces. There is still much to be done here in the way of reciprocal recognition of accounts from hospitals in neighboring provinces. It is childish, to say the least, for a provincial board to refuse a hospital account because an injured workman was rushed to the nearest hospital, which perchance was in an adjacent province.

Nursing problems, particularly as they affect hospitals, are being actively studied by our associations. I think practically all provinces have joint study committees working in conjunction with the central joint study committee on nursing and I believe that the hospital associations are represented on quite a few of these committees. Naturally the status of the small training school is a subject which has been of great interest to our hospitals. Looking over the field as a whole and basing one's conclusions upon provincial studies, statistical data, and other information, several conclusions stand out.

1. The hospitals as a whole have made a definite effort to reduce the number of nurses in training; in the last four years approximately 75% of the training schools have made reductions.

2. In the last year the swing of enrollments has been upwards again. This would indicate several possibilities: an enlargement of some hospitals, a lessening of interest in the effort to balance supply and demand, or perhaps greater economic pressure. Owing to the widely divergent factors which must be considered in estimating the relative cost of graduate nursing versus a training school, clear-cut crystallization of opinion has been difficult to obtain.

3. A third development has been a distinct stiffening of the curricula in a number of provinces. Not only are entrance requirements higher but the standard of instruction has been much improved. In this work the hospital associations have participated. The associations are behind the nurses in this endeavor and in one or two provinces where there is no inspector of training schools, the hospital association has supported the nursing association in asking for this highly desirable office.

As for the actual nursing in the hospitals, one observes several tendencies:

a) Hospitals are being staffed for the minimum rather than the peak census—temporary help can always be obtained.

b) An intermediate service of partially trained ward aides has been developed in some of the larger hospitals.

c) At the same time more nurses have been helped by giving each so many days' work at recurring intervals.

d) In some hospitals the "nurse internship" tides the recent graduate over an awkward year.

WORK OF THE CANADIAN HOSPITAL COUNCIL

No reference to the hospital associations would be complete without a reference to the work of the Canadian Hospital Council. You have already heard the report of the meeting in Winnipeg a year ago, a meeting in which your representatives took a notable and most constructive part. Since then, much work has been done by the various study committees and these reports will be made public in due course when the biennial meeting is held next year. It is remarkable how quickly this national body has become a part of our hospital life. Perhaps this is because all hospitals feel the benefit of the sales tax exemption for instance. Requests for information and advice are coming in steadily and we have got to the point where the assistance which my budget will permit cannot adequately handle the work requested of us.

Of one committee activity I would like to make special reference. The special committee on accounting, of which Father Verreault of Ottawa is chairman, has been doing good work in the field of accounting for small hospitals, and should have at our next meeting something to present of real practical value to our hospitals. Moreover, this committee is closely linked through two members with the American Hospital Association Committee on Accounting and the International one, thus dovetailing rather than confusing these various studies.

This committee, and that on administration and statistics, have arranged with the Dominion Bureau of Statistics to bring the most valuable annual study of the Dominion Bureau more closely into line with the various provincial requirements. A very satisfactory basis of statistical return has been worked out and the hospital authorities of one large province—Ontario—have participated so fully in this move that it is now agreed that the same set of questions will now suffice for both returns; furthermore it is agreed that the hospitals in that province will be required to fill out only one set of returns. That is real progress and we hope it will be but a short time until all provinces will be agreed upon a common basis of statistical return. Then statistical comparisons will mean something and their present chaotic state will be clarified.

These are but a few of the activities of which one might speak. For instance, one could speak at some length on the subject of group hospitalization or the prepayment plan for hospital services, a plan which is being widely adopted all over this continent, including many centers in Canada. The Department of Hospital Service of the Canadian Medical Association is now engaged in making a study of this subject. Perhaps this will come up in the discussion on health insurance.

Finally, of two things we can be certain. In the first place our hospital associations are more active than ever before in their history—hard times make people more interested; and, in the second place, a review of our association program reveals that, while economies and technical difficulties are the major problems, our hospitals workers are taking an ever increasing interest in the general community welfare. We are realizing that it is not enough to merely operate a hospital; we have a definite community responsibility; we, as trained health workers, must take an active part in formulating the health policies and activities of our communities. We have a tremendous task ahead of us, but thanks to you and similar groups elsewhere, our hospitals are emphatically meeting this challenge.

I think our hospitals are very fortunate in Canada; comparatively fortunate at least, for despite our many worries—and they are bad enough—we are better off than either the British, or the American hospitals. I

might even include the Dublin hospitals, despite their sudden wealth, for information received would indicate they are having considerable trouble with the Government over the release of these funds and far-sighted hospital leaders in Ireland tell me that the sweepstakes have killed perhaps for many decades the almost completed plans for a coördinated and more efficient hospital system in that city. But we do not have here, as they have in England, our voluntary hospitals penalized rather than assisted by the governmental health plan and in direct competition with the recently organized municipal hospitals. Where we have a municipally owned hospital in competition with a voluntary non-profit public hospital, as in Calgary, Edmonton, Regina, Ottawa, Hamilton, London, and other centers, both hospitals receive the same governmental assistance and the non-municipal hospital usually receives the customary municipal remuneration.

Our American friends are in a sad plight just now. As a trustee of the American Hospital Association, I am kept closely in touch with their problems. With the exception of a very few states, state grants to hospitals are quite unknown. The majority get little or no municipal grants, even though no municipal hospital may be available to handle the indigents. There are distinct disadvantages in endeavoring to separate private and public patients into different hospitals, particularly in times of depression when private patients are few in number; and the municipal and provincial aid which we have enjoyed, even though inadequate, for many years is just now being seriously sought by the American hospitals. For the past year or two Federal aid particularly has been sought, largely because it is flowing like water into other channels, but this year the American Hospital Association has endeavored to follow the Canadian precedent by steering these requests toward state and municipal support.

REVIEW OF SPECIAL PROBLEMS

A few of our special problems in Canada might be touched upon. Finance—one most pressing one—crops up in practically every discussion, for most hospitals are in the red and the rest are already scorched, so I shall not linger on that point here. At the same time it is pleasing to note that very few of our hospitals have closed their doors; nurses and employees have taken drastic cuts but still loyally carry on; and trustees seem to appreciate the deep obligations of their trust more than ever before.

Moreover, we are faced with a changing demand for accommodation. The former cry for more private accommodation is replaced by a demand for public or cheap semi-private accommodation. The superintendent of one large hospital told me the other day that his public wards were bulging

and his private pavilion but one-sixth occupied. This experience has emphasized the necessity of evolving elastic and easily converted types of accommodation in our hospitals, a principle few architects seem to appreciate. Now hospitals are doing the best they can, converting large private rooms into two-ward three-bed ones, reallocating floor space, and shifting service departments to make more cheap accommodation.

Low bed occupancy is another problem despite the overcrowding of our public wards. A recent analysis by our office revealed that in hospitals with training schools, the average occupancy was but 58.4%, while in those without training schools, it was but 50.8%. This of course is related to the financial stringency and the cost of hospital care and our hospitals are attacking it upon that basis. Rates are being revised, flat rates adopted, for instance, in obstetrics; large wards are being broken up to admit a wider variety of patients; new services are being instituted; some house surplus nurses and some rent offices to doctors (not a bad idea, either); some close down a wing. Others have adopted group hospitalization or the prepayment plan for hospital care and studies of these experiments would indicate that the principle at least is sound and that we shall soon have sufficient data upon which to base rates.

MEDICAL STAFF QUALIFICATIONS

A marriage which will never face the divorce courts—which could not endure even a separation—is that of the hospital and the doctor. Neither could last long without the other. But that does not imply that the odd family scrap should not be anticipated, as many a broken rolling pin will testify. When we look back a few years, however, it is very obvious that the two partners have grown much closer together. There is much more coöperation than ever before; the medical profession has become much more hospital-minded, the hospital medically-minded, and in this connection I wish to pay particular tribute to the efforts of one of our own men, Dr. M. T. MacEachern, who has done more perhaps to bring this about than any other person.

Of the many phases of medical relationship I shall mention but one—that of the increasing difficulty of deciding who shall do major surgery and practice other specialties in the hospital. This is a pressing problem for two reasons: (*a*) the increase in specialism and (*b*) the expansion of our small hospital units throughout rural Canada. Fortunately there is increasing evidence that the medical staffs are making a serious attempt to solve this problem themselves. In Alberta no doctor can announce himself as a specialist unless he has obtained a special certificate to that effect. The establishment of the Royal College of Surgeons in Canada, granting fellowships after rigid examinations as in Great Britain, will give us in

another decade or two a widely recognized standard which will simplify to a considerable degree this matter of qualification, particularly for heads of services. It is interesting to note that in one leading hospital at least there is a definite movement to limit all future staff appointments to holders of postgraduate fellowships in various branches of medicine. The formation of a joint super-board to maintain the highest standards for all specialty boards in the United States, upon which board the hospitals are officially represented, is a distinct milestone of progress also.

PUBLIC RELATIONS

Finally, I would like to say a few words on the subject of public relations. We talk a lot at conventions about the vital importance of telling the public what we are doing, but with a few brilliant exceptions we do comparatively little about it. Only a few of our hospitals have made more than sporadic efforts to supply the local press with properly prepared hospital data. The public has been educated to want health news; it has been fed an endless lot of commercially inspired drivel, most of which has no scientific background, and as far as hospital costs and motives are concerned is often absolutely untrue. Every hospital receives all sorts of publicity material in its hospital magazines which could be rewritten and applied to the local situation. How many hospitals have information booklets for patients and visitors? How many make your annual report more than a mere statement of receipts and expenditures? How many invite service and other clubs to dine at the hospital once a year? How many trustees or doctors or superintendents speak to clubs and groups on health? The public is only too keen to hear you—to be told, for instance, what progress has been made in health; how the average age has been increased 18 years in the last century; how the Panama Canal was the graveyard of thousands of workmen and could not be completed until yellow fever and malaria had been stamped out; how in the fourteenth century one-quarter of the population of Europe died from plague; how in the first half of the eighteenth century approximately three-fourths of all infants died before reaching five years of age; how 150 years ago, before Jenner discovered how to control smallpox, in Glasgow one-fifth of all deaths were due to smallpox, and in France at that time one in 10 of all children died of smallpox. It has been recorded that in London every third person on the street was pockmarked. That is something for our anti-everything friends to smoke on. Now, if an epidemic does occur through laxness in vaccination observance, practically the only deaths are among the unvaccinated.

But to return to our public relations; much more could be done than has been done and in this connection we should not forget the necessity

of having not only a satisfied patient but a wildly enthusiastic patient—and you can turn them out that way, too. Let me close with an illustration of something which happened recently in an eastern hospital. A woman was in this hospital making a tedious convalescence and just by chance the superintendent happened to hear that her wedding anniversary would occur the next day and that for the first time she and her husband could not have dinner together. That was enough. He called up the husband, confirmed the date (they say there are husbands who can remember these dates) and next day the downcast wife got the finest tonic that she had ever received when at the dinner hour in came a table set for two, with flowers, place-cards, and everything, and friend hubby bringing up the rear! Was that not worth while?

IMPORTANT

On September 26, while traveling to the convention hall to attend the sessions of the American Hospital Association convention, the car in which Mrs. Harry T. Armstrong was riding was struck by a bus and Mrs. Armstrong was fatally injured.

The family of Mrs. Armstrong would greatly appreciate the service if any eye witnesses to this lamentable accident, or any occupants of the bus, would send their names and addresses to the Executive Secretary of the American Hospital Association.

Erratum. The BULLETIN regrets that in its December issue it ran a statement to the effect that Dr. N. B. McWilliams had been appointed superintendent of the North Adams Hospital, North Adams, Massachusetts. This is in error. Miss Mary Larter, one of the best known of New England superintendents, has been the superintendent of the North Adams Hospital for the past 16 years and no change in the administration of this hospital has been made or is contemplated.

Hospital Ethics*

SISTER M. MECHTILDIS, O.S.F., R.N., B.A.
Superintendent, St. Anthony Hospital, Oklahoma City, Oklahoma

"I AM COME that ye might have life and have it more abundantly." These are the words of the Divine Master and, to me, the most profound, holy, and potent program ever proclaimed for social good and for the blessing of mankind. To some these are the words of the God Man, the light of the eternal Father. To others they are the words of a man of God, a gentle, noble, and benevolent spirit. For others still they are the words of a strolling prophet, deluded in his burning zeal, who came

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to a pathetic and tragic end. Truth, confusion, and conflict move round the mission and the message and the Man. So it seems there must ever be clash and conflict between those who seek life in His Name and those who cannot or will not accept the program of a more abundant life from Him.

One of the means of bestowing life is the hospital as a social institution. For me a hospital is a wonderful field in which to carry out the healing mission of Christ. The abiding Christ lives in the ages. He weaves Himself into the intimate affairs of life. He gives a consecration to the social institutions of life and so men find, in all the ills our poor flesh is heir to, the more abundant life in His Name. I should prefer to pause and to ponder on that thought and hold the vision of my hospital and yours as the abiding Christ bestowing life.

Perhaps we had better define our terms—hospital and ethics. In the ancient world hospitals were unknown. Splendid as was the civilization of Rome, that culture had no word for hospital. As the word was unknown, so was the institution. For slaves only there was a sick bay and

*Address delivered before the Oklahoma State Hospital Association.

the word tells what it was—a porch where the sick slave could lie out from toil. The only references to the care of the sick in the gospels mention these porches, where the blind and the lame and the withered lay by the pool of healing waters.

The early Christian ages had no hospitals. The pilgrims had shelters where they could receive hospitality in the name of Christ. They were received as a *hospes,* or as a guest of Christ. Their shelters became a hospice or a place of hospitality in the name of Christ. In due time these places of hospitality for pilgrims became places of refuge for the sick, and the sick, in place of the pilgrims, became the guests of Christ and the hospice became the hospital. The guest of Christ, the house of Christ, and the hospitality of Christ developed into hospital service through the ages. We may smile at the crude limitations of science in that ancient hospital service but we should do well to match their cleanliness, devotion, and serene peace. Then a decline set in. Hospitals became thoroughly disreputable and hospital service was held in contempt.

Florence Nightingale, the Sisters of Charity, and the Ladies of Mercy were souls whose burning zeal lifted the hospital from its degradation. Since those days we have had hospital reform. The progress has been constant and consistent. In our own day the trend is forward and upward to better and higher things. The challenge to every hospital, great and small, is to make its own contribution to the progressive movement. My message is, briefly, that hospital ethics is a very significant factor and provides a field in which all hospitals may be of mutual assistance.

Let us, then, define ethics.

Ethics is the science of human acts in relation to their ends. The acts of a hospital must be in the right relation to the ends or purposes which the hospital wishes to attain. The science of that right relation is called ethics. It must be obvious that the acts of the hospital may have various ends or purposes. Thus there are moral ends, legal ends, professional ends, and social ends. Accordingly we have moral ethics, legal ethics, professional ethics, and social ethics. Our contribution, then, to the progress of the upward movement in hospital service will depend very significantly on what ethics we hold and keep.

1. *Moral ethics.*—The acts of a hospital touch on morality, a question of right and wrong that has its sanction in conscience, that holds itself accountable to a supreme lawgiver. The conclusions of moral ethics are not the prescriptions of religion. They are conclusions arrived at by sound reasoning. Owing to different training, moods, and points of view, some will accept and others will choose to reject the conclusions of moral ethics. The point I make is, they cannot successfully refute them with sound

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reasoning, and that sentiment or expediency are not a valid basis for right and wrong. In moral ethics the problems that confront the hospital move round these three principles:

1. The right to life.
2. The right to the integrity of the body.
3. The right to place a cause that has a two-fold effect, one good and the other harmful.

On the right to life I hold that this right rests with the Creator of life. Man does not hold dominion over his own life. This right rests with the Creator and the only time He cedes or grants this right to life is against the evildoer or malefactor. That is a conclusion of right reason. From that premise it follows necessarily that no man can ever do any act which *directly* injures that right to life of any human being. No individual, no code of ethics, no expediency, no necessity can ever bestow, under any circumstances, the right to *directly* injure the right to life. That principle comes up for application in abortion, and craniotomy. It makes no difference whether the abortion is malpractice or therapeutic. It makes no difference whether craniotomy is indicated or expedient to save another life or you incline to recognize a prior right to life. Any act of a hospital aiding and abetting the direct injury to life under any pretext whatsoever is morally wrong.

Under the right to the integrity of the body we have all forms of mutilation. Man is endowed with the right over his body and its functions. To destroy any organ or major function of the body, except to preserve life or for the maintenance of general health, is a perversion of order and morally wrong.

Let us apply this principle to other problems. Can you remove both healthy tubes? Can you remove one healthy tube when the other is infected? The answer is obviously "no." You cannot morally remove any function except for the life and general health of the patient. No other pretext can affect the case.

The third problem is that of an act that has a two-fold effect, one good and intended directly, and the other harmful and permitted indirectly. The principle is that you can place a cause good in itself when from that cause there follows a two-fold effect, one good and intended directly and the other harmful and permitted indirectly for a grave cause. Here you have the ectopic foetus and the indirect abortion. The tube is ruptured by an ectopic foetus. You excise the tube to stop the hemorrhage; thus, a good act is intended. The foetus necessarily dies, a harmful act permitted indirectly for the cause of saving the patient. Or again, you remove the

acute appendix of a pregnant woman. The operation may, and sometimes does, cause abortion. The good act is intended directly, the harmful act is permitted indirectly for grave cause.

It is only fair to say that some conclusions are none too obvious and plain and in these matters moral ethics follows the safer course. I make no pretense at expounding moral ethics or of vindicating the moral ethics I hold. I merely maintain that there is a definite set of principles recognized by competent specialists in that field. I accept their findings and adhere to them as my ethics, and in doing so I feel I am making my contribution to hospital progress. I urge that every hospital search and see and decide that hospital acts have a relation to the right moral order.

Second, the acts of a hospital have relation to legal ends. Consequently, we have legal ethics. At the outset let me state that there is some confusion between legal ethics and moral ethics. Thus an act may be legally right and ethically wrong, such as therapeutic abortion and sterilization. The acts of the hospital must help to attain the common good. Birth registration, qualification of doctors, nurses' keeping of records, and a world of hospital acts have relation to the public welfare as embodied in the law. I am of the opinion that we make a contribution to hospital progress when we know these laws and keep them, and that we are not legally ethical when we ignore them or evade them.

Again, the acts of the hospital have a relation to those in the professions of healing, the doctors and the nurses, and we have professional ethics, which prescribes the right procedure. An act may be morally right and legally right but wrong or prejudicial to the healing profession. The acts of the hospital to be ethically right must promote the interest of the profession. Thus direct advertising, fee splitting, or failure to join or qualify for the medical organization may violate no moral or legal right and still be professionally wrong or at least prejudicial. How shall an ethical hospital act in relation to the code of ethics adopted by an organized body of those in the healing profession? There are questions here, like fee splitting, where fools rush in and angels fear to tread. There are dozens of problems and pretensions that would be fearfully intricate and bothersome, if the ethical hospital could not choose a convenient way out. Let the organized body of doctors and nurses deliberate for their own good. Let their conclusions be definite and compelling. Then let the organized body coördinate the ethics of an ethical hospital with the ethics of the professional body. That is my conception of a hospital professionally ethical. It promotes, coöperates, and enforces, to the end that those high ethical standards adopted by professional bodies shall prevail against the professional chiseler of every stripe. Lastly there are acts

of the hospital that relate to the patient and to other hospitals. Thus we have social ethics.

Hospitals are but lengthened shadows of the people who keep them. We have religious hospitals, clinical hospitals, municipal hospitals, and industrial hospitals. But in the final analysis the hospital is for the patient. There have been eminent surgeons who have successfully indicted hospitals as unreasonably expensive. There are hospitals committing themselves to bargains for patients and a sort of lottery for sickness. There are hospitals that reflect unduly the bias of the management. They are too clinical, too financial, too mass-productive, too everything, in fact, but hospitable to the patient who is sick. The social relation of the hospital is not to the clinic, the board of directors, the staff. In any case the social obligation cannot be with any interest that conflicts with that of the patient.

The patient is entitled to justice, competency, and devotion. The charges must be just. Shiftiness in the matter of rendering what is fully due for the price paid is as reprehensible in a hospital as in any other form of service. The personnel should, by all means, be competent and qualified according to accepted standards.

There must be devotion. The patient is sick and needs it. I have the woman's point of view. I think devotion for the sick means womanhood at its best in all contacts of hospital and patient from the switchboard to the front office. The hospital has social obligations to the community. Small hospitals are good hospitals. They can be as good as any in the world if they are properly correlated to the talent and facilities of great hospitals. Thus there would be no ill in the community with whom the small hospital could not cope if our social ethics had compelling force.

Finally, our hospital acts relate to other hospitals and to the general hospital movement and organization for hospital progress. Invidious competition is absurd. To be reactionary and obstructive to light and leadership is dishonorable and the negation of social ethics.

I have spoken too long and trespassed on your kind indulgence. The topic is vast, far-reaching, and significant. The times hold a challenge to every hospital, great and small. The trend is upward and onward. We must make our contribution to the upward movement. Let that offering be one which we can all make in the vast domain of Hospital Ethics. They cover the whole field of the acts of a hospital in relation to the ends to be obtained. Moral ethics and legal ethics, professional ethics and social ethics, that are held like a creed and kept like a vow—let them be our contribution to progress and the more abundant life that came to man through the wondrous mission and dedication of healing.

Hospitals Now and Then*

FREDERIC A. WASHBURN, M.D.
Commissioner of Institutions, Boston

THE STORY OF THE BUILDING of the voluntary hospitals of the United States is a long one. For the purposes of our discussion it may be epitomized. We may disregard the infirmaries or almshouses which preceded the regular hospital establishments, although it was the contemplation of the shortcoming of the former in the care of the sick and the insane which furnished the motive power for the foundation of the latter institutions. This was notably the case in our own city of Boston.

The first three voluntary hospitals were established in what were then the three largest cities of the land, Philadelphia, New York, and Boston. The earliest of these, the Pennsylvania Hospital, was opened in the year 1752. These three hospitals were much alike in their scope and planning; each had two branches, one for the insane and one for patients with acute general diseases. We are concerned today with the general hospitals, not the branches for the care of the insane.

These general hospitals were organized like the English hospitals of the period. Their patients were the poor only, those who were unable to pay their doctor and very small sums, if anything, to the hospitals for their board. The staff of doctors was unpaid in money though many times richly rewarded by the experience gained and increased reputation because of connection with the hospital. Each of these three institutions had an agreement with a medical school whereby teaching was permitted in its wards. In most instances the important teaching positions in the school were held by members of the hospital staff.

These original hospitals were privately managed institutions. Their funds for building and endowment were for the most part raised by public subscription and generous gifts and bequests from the wealthy, fortified by contributions from the state. Their destinies were presided over by a board of trustees, the majority of which while elected by a hospital corporation were practically a self-perpetuating body. Other members of the board were appointed, in the instance of one of these hospitals, by the Governor of the state. Members of the staff were appointed by the trustees, usually upon nomination of the staff.

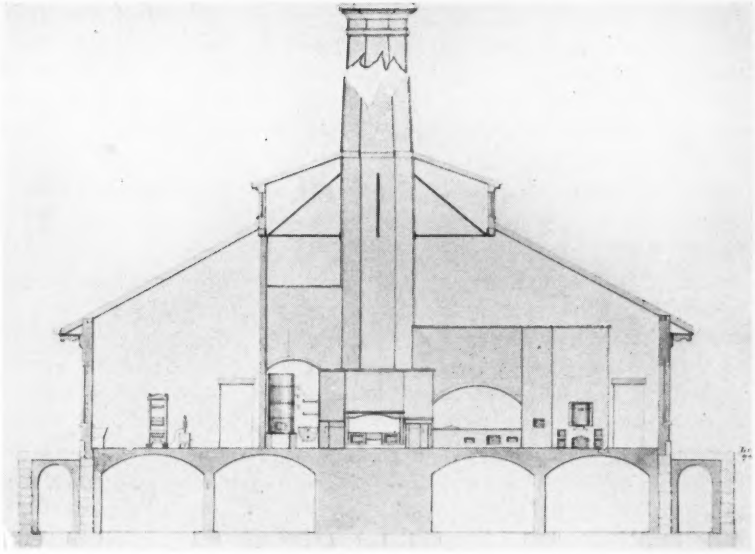
As the country grew in population and area other hospitals were founded and governmental hospitals began to appear. We are not concerned for the moment with the Federal hospitals of the Army, Navy, and Public

*Ether Day Address.

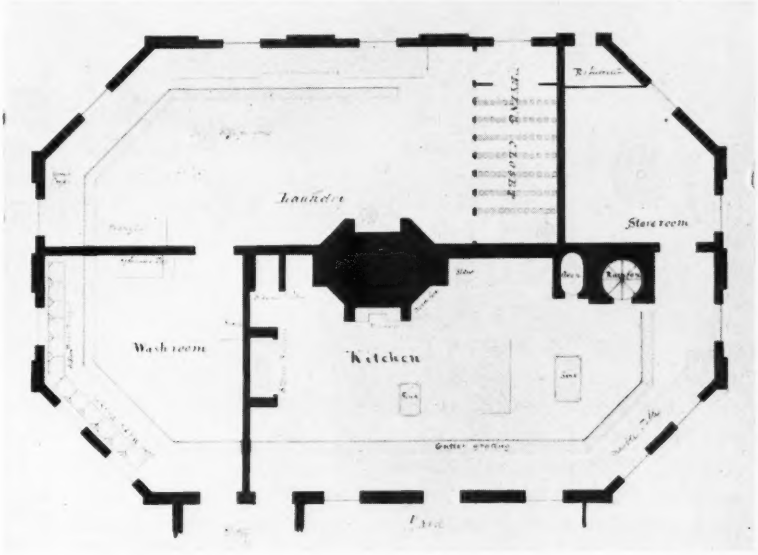
Health, Marine or Veterans Hospitals. The governmental institutions in which we are interested this afternoon are the municipal and county hospitals. The relief to be furnished the sick poor by voluntary hospitals and private benevolence was naturally limited. The demands of this group outgrew the facilities which could be furnished by the voluntary hospitals from free bed funds or annual gifts for the purpose. After the Civil War in the Nineteenth Century, and in the Twentieth Century, many municipal and county hospitals were founded for the care of destitute citizens. Thus the support of the bulk of this group in time of sickness was placed upon the tax funds where it properly belonged. Nevertheless a very large measure of relief of the sick poor has been and is being given by the voluntary hospitals of the land. In the instances of Maine, Connecticut, Pennsylvania, and Mississippi grants are made to privately managed hospitals from public funds. This is not the best way of assisting these hospitals from tax funds. In other instances, notably in New York City, voluntary hospitals are reimbursed by the city on a per capita basis for the care of its indigent sick. This is a fair and proper method if the per capita sum is fixed at a point which will reimburse the hospital for the expense incurred.

From the simple beginnings which have been described, hospitals have vastly increased not only in number but in complexity. This has been most noteworthy in the last 30 years. With the coming of anesthesia, the knowledge of asepsis, the x-ray, and the many laboratory procedures necessary for diagnosis and treatment, more and more has it appeared necessary to bring to hospitals patients who were formerly treated in their homes. This is especially true of surgery.

When it came to be realized that the patient's chance for correct diagnosis and in many instances for life itself was much more favorable in the hospital than in the home, there developed a demand first that private wards for the well-to-do should be provided at our hospitals and then that provision should be made for patients of moderate means. Fortunately this demand came early enough with us so that these facilities were provided in connection with our established hospitals before physicians had to any large extent acquired vested rights in their own small hospitals or "nursing homes." If one is in doubt about our favored situation in this respect he has but to compare it with that of England. The modern hospital situation is further complicated by the development of schools of nursing, medical social service, dietetics, libraries, and occupational therapy. In our larger hospitals the numbers of resident physicians and surgeons and of interns have enormously increased. In teaching hospitals the medical students are introduced to regular duty in



Cross section of old kitchen building, Massachusetts General Hospital, showing laundry and kitchen. It is now being used as a laundry. Built 1846-47



Floor plan of old laundry and kitchen building

the wards as clinical clerks. With all these factors, together with the management of ambulances, a large general store, one or more drugstores, kitchens, dining rooms, pay cafeterias, laundry, a power house, and shops for carpenters, painters, electricians, and other mechanical trades concerned in maintenance and repair, it is evident that the modern hospital is indeed a complex institution.

With the clinical developments of which we have just spoken staff organization has changed. From the simple form copied from our English models where all professional service was unpaid, where the staff was large and its members rotated in caring for the patients, we now have in our large teaching hospitals with the voluntary staff a full- or nearly full-time chief of each professional department who, usually paid by hospital and medical school, devotes himself to the interests of that department and forwards the care of the patient, medical education, and research. Such nearly full-time chiefs of medicine, surgery, or other clinical branches encourage enthusiastic young men to devote much time to the advancement of knowledge, each in his own specialty but each with close contact with other special departments and their endeavors. The presence at the hospitals of laboratories with their full-time, skilled chiefs, laboratories of pathology, chemistry, bio-chemistry, bacteriology, roentgenology, metabolism, and others not only make the work of these ardent young men and women in the clinical groups possible and effective but furnish the opportunity for advancement of knowledge and the training of young men and women in each of these departments.

Our ideas of the scope of hospital administration and such administration itself have greatly expanded in the last 20 or 30 years. The training and equipment which was needed by a hospital director a generation ago is still needed but vastly more is necessary also if he is to meet satisfactorily the hospital problems of these times. He must clearly see the objects of his hospital, first, the kindly, skillful care of the patient with all the hospital's forces directed primarily toward making for him a correct diagnosis and when this is made providing him with every facility known to modern science to effect a cure. All this accompanied by the most kindly nursing and thoughtfulness of the patient's best interests in all directions. The idea that the hospital exists primarily for service to its patients and the community must be thoroughly learned by all its officers, staff, and employees. The hospital director then must clearly see the other main objectives of his hospital: education—that of the public in matters of health, the medical education of physicians of the community, the staff of the hospital, its resident physicians and interns and medical students—education in all the allied branches of medicine which function

in a hospital; hospital administration, nursing, social service, dietetics, libraries, the technique of laboratories, occupational therapy, and others. Hospitals may well accept the function of assisting in the education of the public in the avoidance of medical cults. People who are credulous and uninformed are readily victimized by plausible charlatans or by sincere but ignorant and misled cult enthusiasts. Physicians, health departments, and hospitals have not done their duty to the public in helping them to protect themselves. Hospitals and their representatives can advertise, speak over the radio, post bulletins and in other ways frankly and openly tell the people just what scientific medicine is, its possibilities and its limitations, and warn them against the fads and cults upon which so much money is wasted. A similar plan of publicity may help to warn people against spending their money on patent medicines and high priced proprietary preparations most of which have equally effective low-priced substitutes.

A third function of the hospital which he must bear constantly in mind is the advancement of human knowledge in all medical branches and in the functioning of the body of men in health and disease.

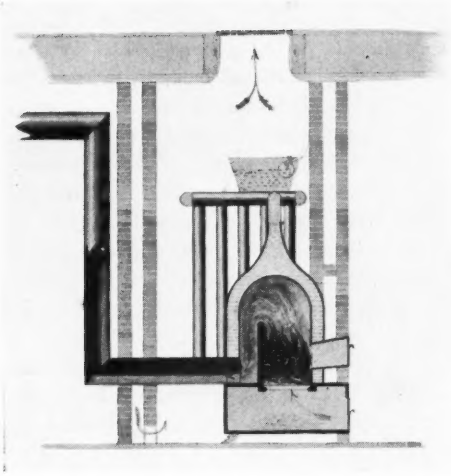
A fourth of the hospital's obligations is the public health. The education of the community in matters of health has already been touched upon. The hospital has a great opportunity here through its intimate contact with members of the community, patients both house and out-patient, their relatives and friends. Many hospitals have classes for various disease groups—diabetics, cardiacs, and others. There are classes for prospective mothers and for mothers and children. Hospitals can help the public health by prompt hospitalization and isolation of contagious disease, by development of a follow-up system, and the discovery and treatment of contacts in venereal and other contagious disease.

The hospital director is the executive officer of the trustees of the hospital. He should also be the secretary of the Executive Committee of the professional staff. This committee of the staff, if it does its full duty, is one of the most powerful of forces for the good functioning and wise advancement and development of the hospital. Their job is to nominate to the trustees for all staff positions. The reputation of the hospital, the determination of its future policy, whether it advances with the times and makes valuable contributions to medical knowledge or whether it lags and deteriorates, is bound up with the character of the members of this Executive Committee of the staff and the thoroughness and intelligence with which they do their work of nomination and consideration of hospital policies and their recommendations to the trustees.

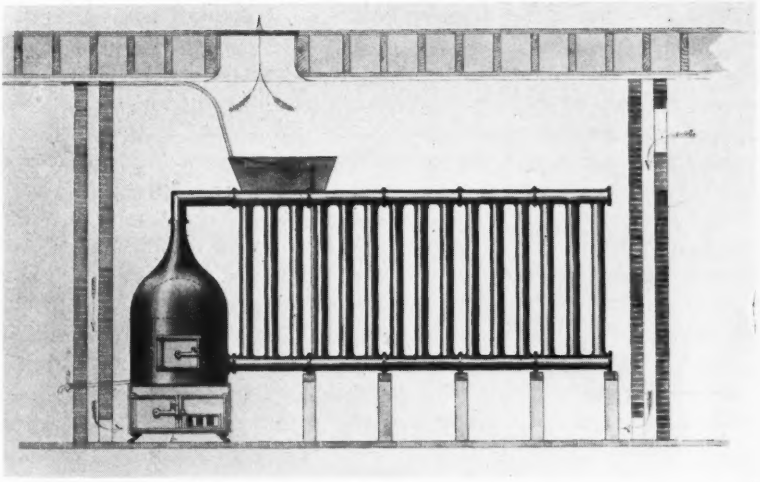
Such a committee, composed of the right men meeting regularly and acting conscientiously, is a great source of strength to trustees and director.

The competent hospital director must be a good executive who can plan and effect an organization which will decentralize and delegate functions in such a way as to promote economy and efficiency and at the same time keep for himself effective control with a clear picture of what is happening in all parts of the organization. With all this he must leave himself time to take an active part in his national hospital associations and other community and national service.

There never was a time in the history of hospitals when there were so many problems facing them nor was there ever a time when so much thought was being given to these problems and so much useful work in solving them. The country is particularly fortunate in having the great foundations and professional associations to furnish the means and some of the personnel to make these studies. The very exhaustive and important study of the Committee on the Costs of Medical Care has centered our thoughts on how to provide adequate medical care to all the community. The well-to-do are provided with private wards in our voluntary hospitals where they can receive the best of care and pay fees which will properly recompense both physician and hospital. Attempts have been made in a few places to do something for people of moderate means in time of sickness. The Baker Memorial of the Massachusetts General Hospital is an outstanding example of what can be done to give to this group of people the very best of medical care and nursing at a moderate price. Due to generous aid of a large benefactor and many smaller gifts it was possible to erect this building without the necessity of making the patients pay to cover interest upon the investment. The Julius Rosenwald Fund helped share the deficit of the first three years of operation. Every effort is made to keep down the expense to the patient to the lowest point consistent with supplying this group of patients with the best service for diagnosis, care, and relief or cure. To avoid the very considerable expense of special nursing, the floor nursing is made more than adequate. Thus it is necessary to use special nurses only when a patient needs constant care or for a short time immediately after operation. One of the very important contributions to the success of this demonstration was made by the professional staff who volunteered to limit their fees to these patients to very reasonable sums and established a fee table for this purpose. Greatly beneficial as this hospital has been, much as it has helped people of small incomes in time of sickness, nevertheless the fact remains that although average charges are small, maximum charges may still be considerable in instances where a patient stays in the hospital a long time and



Cross section of hot water furnace



Elevation of hot water furnace

requires special nursing. A system of insurance, then, to spread the cost would seem to be indicated. Such insurance plan should probably be voluntary in type, controlled by a non-profit corporation. It should provide for small periodical payments by its members who in time of sickness would find their bills, both hospital and medical, paid for them. What a godsend this would be to thousands upon thousands of men and women who now live in dread of sickness with its unpredictable costs. Such a scheme would allow them to budget their sickness expenses, pay their way in a self-respecting manner, and be assured of the best of care in time of illness. It would assure the payment of modest fees to hospital and doctor and be a blessing to all three parties to the plan. It is quite within the possibilities that voluntary insurance like this will finally be found to be applicable mainly to the better educated and more intelligent groups and that compulsory health insurance which will include hospitalization will be adopted for the masses of the employed. Whichever form, voluntary or compulsory, or both, finally goes into effect it is fair to assume from the experience of other countries that patient, hospital, and doctor will be benefited.

Then comes the question of the care of the indigent. Who is to pay their bills in hospitals in time of sickness? It is a fair statement, I think, that American public opinion and in many cases custom and law demand that this expense be met from public funds. There are many sore situations, however, and much injustice to voluntary hospitals which in many instances are carrying much of this load without recompense. The burden has enormously increased in the last few years. Because of the depression voluntary hospitals have suffered a serious diminution in capital gifts, in annual gifts, and in income from patients. At the same time the demand upon them to care for free and part free patients has greatly increased. Hospitals have responded to this appeal nobly and many have gone into debt rather than turn patients from their doors. Their dilemma should be recognized more generally and steps taken to put their finances upon a more stable basis with a broader community support. I would submit the proposition that the free work done by voluntary hospitals should be limited to what they can pay for from the income of funds given distinctly for that purpose and that these hospitals shall be paid by public funds upon a per capita basis for the cost of any further hospital service given the indigent. Whether these public funds should be municipal or county, state or Federal, would depend upon local conditions. Each community should as far as possible stand upon its own feet. Municipal and county hospitals must of course be used to capacity but when that capacity is exceeded public funds should pay the bills of the indigent in voluntary

hospitals. In figuring the hospital bills of the destitute to be charged to tax funds it may be argued that they should represent only that part of hospital expense concerned immediately with the care of the patient. The costs of medical education and research may well be deducted before the city or county bill is figured. Where, then, is the money to come from to defray the expense of education and research? It may come from the medical schools and universities in part. If the fountain of private gifts runs dry, nation or state may need to make grants for this purpose. In many states which support universities appropriations for such purposes are regularly made now, though not to private hospitals except in the instances already quoted. It may be suggestive of one very good way to solve the problem of conducting a municipal hospital and keeping it free from politics and maintaining high standards of care if one studies what has been done by the city of Rochester, New York, at the Strong Memorial Hospital. There the city has given over the care and nursing of the patients, with many administrative functions, to the University Hospital and its staff.

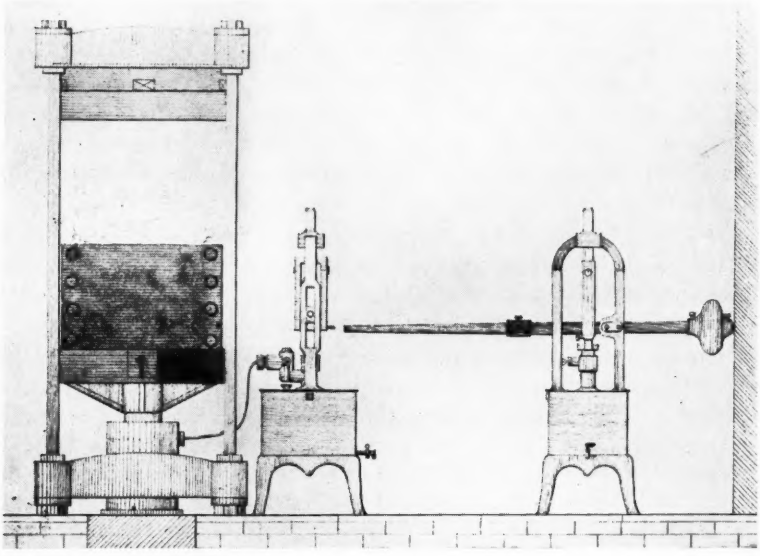
It may be that hospitals should shoulder the burden of visiting the indigent sick in their homes. If this is done, the city or county should reimburse the hospital for its payment to the doctors and nurses for the services rendered, always upon a per capita basis.

Bequests and gifts to endowment and annual gifts for maintenance will always be required by voluntary hospitals, for they must build and renew to keep up with the progress of medicine and the needs of the community. Until municipalities and counties can be educated to pay for services rendered the indigent and until group hospitalization is installed in such a way that wage-earners and people of moderate means may pay their bills on insurance principles, large sums must annually be contributed to our voluntary hospitals, or many of them will be unable to continue.

The question of the remuneration of physicians on the staff of the hospital for services performed in the care of indigent patients is a hardy perennial which flowers with especial vigor in hard times. It cannot be answered lightly nor would the answer be the same in all voluntary general hospitals. In large teaching hospitals chiefs of staff and some of their assistants are paid salaries and included in their duties is the care of indigent patients in their wards. Even in these hospitals the bulk of the work in the routine care of patients, both house and out-patients, is done by a volunteer staff. It may fairly be argued that these men are amply repaid for their service to the poor by the opportunity which their position gives them to keep in touch with the advances in knowledge of their profession, to gain experience and the prestige which their hospital connec-

tion gives them. When the staff is a closed one its members may hold privileges of having patients in the private and semi-private wards which are of great value to them.

These arguments would not hold so true of general hospitals where no teaching is done or research conducted. There are difficulties besetting the path of paying the physicians caring for the indigent patients in these hospitals. If the hospitals in question be public hospitals there is the danger that paid positions upon the staff would become political plums



Hydraulic press in use at Massachusetts General Hospital for 50 *years, until* 1896

and appointments would be made not from merit but for political reasons. This is a real danger in public hospitals and to a lesser extent in voluntary hospitals. What would be the source of the money for these payments? Certainly not from the funds of voluntary hospitals. A compelling reason for this answer is that such funds are non-existent. It would seem, then, that the only way of paying the hospital doctor for his care of the indigent patient would be upon a per capita fee basis from tax funds. If this were done for voluntary hospital staffs the staffs of public hospitals would expect it and the way be opened for a spoils system in our hospitals. We should think long and carefully before we start such a system.

One might continue to speak of many other hospital activities that are in the air or are really taking place. A recent tendency in general hospitals to add psychiatric wards is to be noted. This encourages us to believe that progress in our knowledge of mental diseases may soon equal the advances made in our understanding of other forms of sickness. Such information is far more likely to come to us when patients with early symptoms of mental trouble are hospitalized in a great modern general hospital where teaching and research are encouraged than when these patients are by themselves, away from the experts upon the other ills of the human body and from the laboratories in which these men work.

Hospital councils are being formed with their group planning as opposed to the unrestricted individuality of the hospitals in the past. Mrs. Mary Hicks Bachmeyer, who has just made a report upon Hospital Councils to the Council on Community Relations and Administrative Practice of the American Hospital Association, says:

"Along with other agencies at the present time, hospitals must necessarily face some restrictions of the right of individual institutions to do as they please. There is an increasing obligation upon institutions to adapt their policies or programs to the needs and desires of the community. Given the fact that in many cities a large number of hospital beds are not occupied and that this condition existed before the depression, there can be no doubt that the supporting public will demand careful scrutiny of the use of hospital facilities and particularly of future expansions and re-locations. Relationships between governmental and voluntary hospitals in many communities and of all hospitals to the organized medical profession are also problems of major importance at the present time. With none of these questions can individual hospitals deal successfully while acting alone."

There can be little doubt that we shall see more community planning in the future than in the past and that hospitals like all men and other institutions must join in such planning.

We might speak of the effect upon hospitals of the recovery acts passed by Congress in the last year or two—and the success of the American Hospital Association in getting hospitals relieved from the application of many of them—the dangers to voluntary hospitals of extreme socialization by the extensive building of Federal hospitals or possible attempts from Washington to control the voluntary hospitals—of the studies now being made by the Council on Community Relations and Administrative Practice of the American Hospital Association in the way of standardizing and clarifying hospital procedures and the coöperation with that Council of the College of Surgeons and the American Medical Association. Suffice it to say that all this indicates better hospital coördination, better planning, and more mutual help by all professional groups connected with hospitals.

The College of Surgeons and its distinguished president, Dr. Greenough, have set an example of willing coöperation and helpfulness and hospital administrators are grateful to them. Just as in most individual hospitals, Staff and Administration are working harmoniously for the common good, so it should be in the broader field of the country-wide associations. A beginning has been made; let us make sure it continues.

Review of Books

TEXTBOOK OF STERILIZATION. By Weedon B. Underwood.

120 pp., illus. The American Sterilizer Co., Erie, Pa., 1934.

The author's engineering training and many years' experience in the designing of sterilizing equipment demand that his statements be treated with respect.

The dangerous fallacy that the pressure attained within the sterilizing chamber is a safe index of the temperature and therefore of the sterilizing efficiency is emphasized and explained. The safe method of depending only on an accurate thermometer placed at the discharge outlet of the chamber—the point of lowest temperature—is fully demonstrated.

As a result of painstaking research, proper methods of packing dressing sterilizers are developed and fully explained with well conceived illustrations.

The author pays particular attention to the development of a proper technique for the management of all sterilizing procedures for dressings, instruments, and utensils.

The chapters on the preparation and sterilization of solutions, and on the design and management of water sterilizers, contribute many ideas which have never before been generally presented to the hospital field.

The book is well written, well printed, and fully illustrated. Its lessons should be carried to every person having responsibility for the preparation of sterile supplies, solutions, or instruments.

Quarterly Meeting of the Council on Community Relations and Administrative Practice, Chicago, Illinois, December 9, 1934

AT THE QUARTERLY MEETING of the Council on Community Relations and Administrative Practice held December 9 at the offices of the American Hospital Association, group hospitalization plans received extended discussion. The report presented by C. Rufus Rorem, the Council's consultant in group hospitalization, declared that group hospitalization plans continue to thrive in more than 40 cities in the United States and are establishing their economic soundness and acceptability to salaried employees as a means of budgeting hospital bills. The city-wide group hospitalization plan established in New Orleans more than eight months ago now has 5,000 subscribers, and the plan in Cleveland established four months ago has 3,500.

About 1,000 inquiries have been received this autumn from hospitals, physicians, labor representatives, and employers asking for facts and suggestions concerning the organization of group hospitalization plans. The first edition of 5,000 copies of the Association's pamphlet *Group Budgeting for Hospital Care—How to Organize a Plan of Group Hospitalization* has been exhausted. It is now being revised and brought up to date for reprinting. This pamphlet of 32 pages gives a concrete formula for establishing an annual subscription rate, sets forth the essentials of an effective plan, and includes sample contracts and forms in actual use at the present time.

The recent interest on the part of the Federal Government in the health aspects of economic security makes necessary careful study of the rôle of group hospitalization in hospital finance and public health. For the coming year, the Council will devote attention particularly to three problems in this field: (*a*) the collection of actuarial data on the incidence of hospitalization among subscribers; (*b*) the development of methods of including "family coverage"; (*c*) the development of group hospitalization plans in non-industrial or rural areas.

Dr. Michael M. Davis, chairman, reported the engagement of Miss Margaret L. Plumley on a part-time basis to conduct certain studies for the Council, particularly concerning proprietary hospitals and the financial support of hospitals. Coöperative projects of study on various phases of hospital service have been established with committees of the American Medical Association, the American College of Surgeons, the National

League for Nursing Education, and the Association of Community Chests and Councils.

Other studies now under way include: legal status of hospitals, rural hospital needs, hospital privileges of physicians, paying patients in Governmental general hospitals.

Dr. C. W. Munger, chairman of the Division on Nursing, presented a preliminary draft of a report being prepared in coöperation with the National League for Nursing Education on what constitutes "good nursing service" in hospitals. Dr. B. C. MacLean, chairman of the Division on Accounting, reported that a preliminary draft of an accounting system for small hospitals had been prepared, and that the Advisory Committee of accountants expected to have the printed report ready for adoption within a few months.

The report on the organization of hospital councils prepared by Mrs. Bachmeyer and the subcommittee was approved for publication and will shortly be printed and made available to interested members of the Association.

Dr. R. C. Buerki, chairman of the Division on Medical Practice, reported that the trustees of the Association had given final approval to the standards of education of laboratory technicians prepared by the division, and that work on the manual on maternity care in general hospitals and on other subjects was advancing.

President Robert Jolly, Past President Faxon, and Executive Secretary Caldwell met with the Council. The Council members in attendance were: Michael M. Davis, chairman, Chicago; R. C. Buerki, M.D., Madison, Wisconsin; Joseph C. Doane, M.D., Philadelphia; Rev. Maurice Griffin, Cleveland; Basil C. MacLean, M.D., New Orleans; C. W. Munger, M.D., Valhalla, New York; R. E. Neff, Iowa City; Winford H. Smith, M.D., Baltimore.

Nursing Schools—Today and Tomorrow

A SUMMARY REVIEW OF THE FINAL REPORT OF THE COMMITTEE ON THE GRADING OF NURSING SCHOOLS

MALCOLM T. MACEACHERN, M.D., C.M., D.Sc.
Associate Director, American College of Surgeons, and Director of Hospital Activities

EIGHT YEARS AGO the Committee on the Grading of Nursing Schools was organized by a group who hoped, through grading nursing schools, to raise their educational standards. However, the function of the committee was very soon interpreted more broadly so as to include "the study of ways and means for insuring an ample supply of nursing service, of whatever type and quality is needed for adequate care of the patient, at a price within his reach." As stated by the committee, it has "been primarily interested in better education for nurses because better education for nurses means better nursing care for patients."

It is important to realize of whom the committee has consisted. First of all there was a group of nurses representing nursing organizations; physicians representative of medical organizations; a lay-woman to represent the public; and educators who gave technical advice on educational problems.

Dealing with the study of nursing economics, the committee published *Nurses, Patients, and Pocketbooks* and *Nurses—Production, Education, Distribution, and Pay*. Carefully made and widely distributed were the First and Second Gradings of Nursing Schools. *An Activity Analysis of Nursing* was published simultaneously with *Nursing Schools—Today and Tomorrow*. The committee has made, in addition, many other valuable studies in the nursing field.

The program of the committee as originally conceived was to include five years' work but it was later extended to cover a period of eight years: $283,500 was expended in accomplishing the task. But it is hoped that the task is not yet finished. The work of the committee has been of extreme value and importance in pointing the way, in stimulating discussions, in uncovering problems, in revealing deficiencies, and in suggesting remedies. To them is due a debt of gratitude for their excellent work in pioneering. But it must not stop there. We must continue along the pathway to progress, following the trail which they have blazed.

Already the tide of overproduction of nurses has been stemmed, and a substantial reduction made in the number of low-grade schools. But

there still remain many current problems which must be solved if nurses are to be better trained and if patients are to receive better nursing care.

In a chapter entitled "Too Many Yet Too Few," the committee has pointed out that despite the fact that there are numerically too many nurses, there are still many positions for which nurses are not adequately trained and experienced.

Unemployment in nursing is not entirely a result of the economic depression. Studies have proved that during the years 1928 and 1929, considered the peak of prosperity, there was severe unemployment among nurses. The period of depression has merely aggravated the condition to make more serious the problems which have long confronted the nursing profession. Why has unemployment in nursing been so widespread? Partly, because there are too many nurses; partly, because there is not sufficient paid work to keep them busy.

Defining trained nurses as graduate and student nurses, the United States Census Bureau has published the following figures: In the year 1900 there were 11,892 trained nurses in the United States. In 1930 there were 294,189, or an increase of 2,374%. In 1900 there was one trained nurse for every 6,389 people in the United States; in 1930 the ratio was one nurse for every 416 people. During the last four years approximately 100,000 new nurses have been added to the profession.

Why has nursing grown so fast? Undoubtedly, because hospitals are glad to compensate student nurses for the valuable services they render. The profession is attractive inasmuch as it is the only field "in which the student is usually maintained without cost to the family from the beginning of the first year of professional education."

Through insurance studies it has been estimated that on the average about 2% of the population will be ill at any given time. Ninety-three per cent of such illnesses are of such short duration that they rarely require nursing employment. Decreasing the days of potential nursing care also are long-time ambulatory cases. An analysis of these figures has shown that potential nursing employment probably averages one day per person per year. This does not mean that the average person would not benefit by nursing care in excess of one day per year. But there are many patients who either do not wish nursing care, or if they do desire it, cannot afford it. All of this definitely decreases the amount of employment open to nurses.

Granted, then, that there are too many nurses, how then can it be said that there are too few? Because there are still many positions in the nursing profession which are not adequately filled. Because the basic training of nurses frequently omits experience in the bedside care of important

groups. According to the 1930 Report of the Committee on the Grading of Nursing Schools, there is "a shortage of nurses adequately prepared to give high-grade nursing service along modern lines to contagious, mental, pediatric, obstetric, and many types of medical patients. There is a serious shortage of nurses who have had graduate courses in teaching, supervision, or administration, such as would fit them for the more important positions in hospitals and public health organizations."

Commenting on this statement of the 1930 Report, the committee has stated in the Final Report that "We have no need of any more graduate nurses with mediocre training and background. There are altogether too many of them now. We have great need of nurses with training better than that which is given by the typical hospital school. We need trained nurses with a broader experience and better basic professional background. We need more really skillful, professionally-minded bedside nurses. We need nurses who have taken specialized training following the R.N. to fit them for special responsibilities. We need schools for professional training, on a par with the schools of other professions, which will produce a supply of graduate nurses to fill the positions which, in spite of overproduction, are not yet properly filled."

Perhaps the most rapidly developing field in nursing is that dealing with public health. The graduate nurse with special preparation in this field will find expanding opportunities for employment in the immediate future. There are many phases to public health work; it includes maternity and child welfare, communicable disease prevention, school and industrial nursing, as well as nursing care of the sick in their homes on a visit basis. It should be remembered that all public health nursing requires emphasis upon health teaching and supervision of individuals and groups; it requires special preparation through postgraduate courses which include supervised field work or thorough experience on a supervised staff followed by postgraduate courses for advancement.

A most excellent chapter in the Final Report raises the question "What Should a Professional Nurse Know and Be Able to Do?" The patient expects personal and professional services from the nurse. The physician expects all that the patient does and more. He demands personal loyalty to himself. He deems it essential that the nurse shall possess knowledge and judgment as well as technical skill. The hospital administrator expects the nurse to satisfy both the patient and the physician. He demands loyalty to the institution, constant vigilance, and a considerable fund of knowledge. The community expects nurses to meet the needs of emergency situations—in times of war, epidemic, or disaster. It expects health supervision, bedside care, control and prevention of communicable diseases.

The nurse must satisfy all groups: the patient, the physician, the hospital, and the community at large.

The following conclusions on the functions of nurses are illuminating on the question of what should a professional nurse know:

1. All professional nurses, irrespective of the special field in which they have elected to practice, should be able to give expert bedside care. They should also have such knowledge of the household arts as will enable them to deal effectively with the domestic emergencies arising out of illness.

2. All professional nurses, irrespective of the special fields in which they have chosen to practice, should be able to observe and to interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.

3. All professional nurses should possess the special knowledge and skill which are required in dealing effectively with situations peculiar to certain common types of illness.

4. All professional nurses should be able to apply, in nursing situations, those principles of mental hygiene which make for a better understanding of the psychological factor in illness.

5. All professional nurses should be capable of taking part in the promotion of health and the prevention of disease.

6. All professional nurses should possess the essential knowledge and the ability to teach measures to conserve health and to restore health.

7. All professional nurses should be able to coöperate effectively with the family, hospital personnel, and health and social agencies in the interests of patient and community.

8. Every nurse should be able, by means of the practice of her profession, to attain a measure of economic security and to provide for sickness and old age. It should be possible for her to conserve her physical resources, to seek mental stimulus by further study and experience, and to follow that way of life in which she finds those spiritual and cultural values which enrich and liberate human personality.

These conclusions by no means cover the whole field of nursing. But they do point out the essential qualifications of a professional nurse; they do comprise a crucial test of quality, not only of nursing, but also of nurses themselves. Every nurse should study these conclusions carefully to ascertain if she is meeting the qualifications expected of her. Every prospective nurse should be tested with these principles in order that she may assure herself not only that she has the potential capacity for meeting these requirements, but also that she may expend the effort necessary to raise her above mediocrity and make her one of whom the nursing profession with its glorious heritage may be justly proud.

Nursing education as it has been conducted in most hospitals has not been placed upon a professional level. It has been essentially a form of apprentice training, different certainly from the educational training afforded in other professions. The number of students admitted in most institutions is still determined by the number of patients to be nursed—and should the nursing needs of the patients conflict with the educational needs of the students, the maxim always holds good that "the patient

comes first." It cannot be expected in such a situation that education and training have been adequate. Furthermore, students are not able to learn from graduate nurses because there are too few of the latter employed in hospitals which conduct schools of nursing, and those who are employed are primarily concerned with administration, the pressure of which is usually so great that there is little time for teaching.

Unfortunately, there is no national body either in the United States or Canada with the power to raise standards in schools of nursing. The state or provincial board examinations which nurses must pass for registration are not sufficiently strict. There are too few supervisors maintained by boards of nurse examiners, due in most cases to stringent financial conditions or political intrigue. Nevertheless, the attitude of the nursing profession itself exerts a great influence over schools. And standards are being raised because hospitals usually give their superintendents of nurses considerable freedom which it is hoped these administrators will wisely use in improving standards in schools of nursing.

It is not necessarily true that the way to have good nursing is to have a school. Nor is it any more economical as many hospitals are coming to find. The fact is that most hospitals should not maintain schools of nursing. What is it that hospitals wish? To produce graduate nurses? Or is their main function to provide the safest and most adequate care for their patients? Undoubtedly, it is the latter. In order to provide good nursing care it is not necessary to maintain a school of nursing. Trained graduate nurses are certainly more valuable and competent than semi-trained students. Their services are undoubtedly superior, and because of lower salary rates, hospitals can now afford to employ them.

A survey conducted by the Comittee on the Grading of Nursing Schools, in 1927, showed that the majority of hospitals preferred student nurses for bedside nursing. The graduate nurses themselves looked upon hospital bedside nursing as student work. But the trend today is toward all-graduate staffs. Hospitals are encouraging their own graduates, and the graduates of other high-grade schools, to come back and practice the profession of nursing upon the hospital floors. By going into hospitals for regular bedside nursing graduates will be replacing one or two students, thereby reducing the number of new nurses the school will graduate each year. We cannot hope to improve nurse employment so long as schools continue to graduate thousands of new nurses each year to compete with those already in the field. The salvation of the profession, as the committee sees it, lies in the return of graduate nurses into the hospitals, making possible the closing of superfluous schools.

We would all agree that overproduction in nursing has to be stopped. If we adopt a wise solution, we will close many of the nursing schools. In that event hospitals must find some other way of caring for patients without increasing costs. As previously mentioned, the solution lies in the employment of graduate nurses.

One of the factors in bringing graduate nurses back into the hospital for bedside nursing will be a proper realization of the value of maintenance. Too frequently have graduate nurses failed to include the monetary value of maintenance which is provided by the hospital in addition to the salary. She should take into consideration what it would cost to secure approximately the same sort of board, lodging, laundry, and medical care if she had to secure them outside. She should not compute what it costs the hospital but the amount it would cost her. With that figure added, her salary will not suffer in comparison with salaries paid in other fields.

The cost to hospitals of changing to an all-graduate service will vary under different conditions. The committee after a careful study has concluded that "most hospitals with less than 100 patients could probably save money by making the change, even without very careful reorganization of the nursing service. Many larger hospitals could either save money, or break even, or make the change at slight additional cost." Apparently, it is the present reduction in salaries for bedside nursing which has opened the field to graduate nurses.

Hospitals desiring to maintain an all-graduate nursing staff successfully will have to provide for two important conditions. First of all, salaries should be graded according to the difficulty of the work and the amount of responsibility entailed, and every promotion in rank should be accompanied by a substantial salary increase. The second requirement is that the hours of work for institutional nursing should be adjusted to a 48-hour, 6-day week, with one full and unbroken day of rest in every seven, and one month of vacation with pay every year. If hospitals wish to secure high-grade nurses, with a professional attitude toward their work, they must provide satisfactory conditions as well as sufficient salary.

The nursing profession faces a difficult task during coming years, and that is to demonstrate the superiority of graduate nursing service. The committee has recommended that: "Superior young graduates should be encouraged to try floor duty in the better hospitals. Well qualified head nurses, supervisors, and superintendents of nurses should seek positions in good hospitals *without* schools; and, once they secure these positions, should make it a matter of pride to build up a graduate nursing service of which the hospital can boast. There will always need to be schools of nursing, professional schools conducted on a college level. Nurses

connected with them will be doing an important work. But the work done by nurses in the hospitals without schools is fully as important as that of the nursing educators, because if they are successful administrators they will show the hospitals the desirability of the graduate service. If hospitals want students, the sub-professional schools will continue. If they want graduates, the sub-professional schools will close. Every nurse who goes to a hospital without a school, and helps make the all-graduate nursing service a success, renders an essential contribution to her profession."

The Grading Committee has wisely stated that "the outstanding problem in nursing is not to secure adherence to the present standards . . . it is to secure for every school a true professional freedom, without domination either by hospital treasury or by nursing tradition." It is the belief of the committee that when schools of nursing are beginning to organize on a college level emphasis should not be placed on long lists of detailed standards but rather upon a few fundamental conditions proved necessary by experience for a professional school.

Under eight headings are listed the essential conditions which apply to all professional schools and which should be met by professional schools of nursing:

1. *Board of Trustees*

a) Every professional school should be under the control of some form of managing board, whose primary concern should be the conduct of an educational enterprise. The board should not regard the school either as a side line or as an adjunct to some other organization or business.

b) In any professional school, the controlling board should be representative of the community, rather than of one or more specialized groups.

c) The board should decide matters of educational policy. It should appoint executives and faculty, and delegate responsibility to them.

2. *Finances*

a) The governing board of any professional school should be in control of the finances of the school. It should operate on a yearly budget, determined in advance. It is important that the finances of the school should be safeguarded as carefully as would those of any other school or department of the institution.

b) Professional education is expensive. Funds should be drawn in part from tuition fees, but a large part must come from endowments, gifts, or subsidies. Under certain conditions funds may even be derived from payment to the school for student services, but this should be done only on a broad plan, agreed upon in advance, and so safeguarded that there is no way in which the income can be increased or the costs lessened by assigning students to certain services. The school should be free from outside financial pressure when making student assignments.

3. *The Head of the School*

a) The head of a professional school should be a college graduate, with some additional specialized professional training, and with the background of an educator.

b) The head of a professional school should be an educational administrator, able to work with others, and to delegate responsibilities.

c) The head of the professional school should be closely in touch with the everyday activities of the profession.

d) Whether or not the school is connected with a college or university, the head of any professional school should be familiar with the university viewpoint. The director should be in touch with educators in other professions, and familiar with their educational philosophy.

4. *Faculty*

a) In any professional school, a majority of the faculty should be members of that profession.

b) Except for unusual and important reasons, all members of the faculty should be college graduates.

c) Every faculty member of an undergraduate professional school should possess demonstrated teaching ability. Faculty members selected primarily because of professional reputation, or because of their ability in research, may have a proper place in the graduate school. But the undergraduate school needs a faculty, every member of which is a reasonably good teacher.

d) Every faculty member should have had some specialized training in the subject he teaches.

e) The members of the faculty who teach professional subjects should have practiced the profession in the field, not merely studied it in a school. They should be in current touch with the activities of the profession.

f) Members of a professional school faculty, who are not themselves members of that profession, should be familiar with the professional applications of the subjects they teach.

g) All members of a professional school faculty should be able to give instruction on a college level.

5. *Students*

a) The students admitted to any professional school should be carefully selected (as to health, character, personality, etc.) to fit the special requirements of that profession.

b) The educational standard for admission to a professional school should be no lower than the entrance requirements of leading colleges.

c) The students in a professional school should be able to carry work of college grade throughout the course.

6. *Curriculum*

a) What the students are taught should be determined not by the convenience of the school but by the needs of the community for professional care.

b) If the professional school does not itself grant a degree, its courses should be so arranged that credit leading towards a degree may be secured within a reasonable time by those students who successfully complete the professional training.

c) In planning a professional curriculum, while the claim of both new and old methods should be carefully considered, there should be no blind enthusiasm for the new simply because it is new, and no blind loyalty to the old simply because it is old. The new should be avoided wherever investigation indicates that the old is probably better. The old should be abandoned wherever the new seems more hopeful. The traditions of the profession should be respected and understood, but not sanctified.

d) There are two great problems in planning the curriculum for any professional school: The first is to identify the skills, viewpoints, mental habits, knowledge, and traits of personality which are basic to the proper practice of the profession. The second great problem in the planning of a professional curriculum is to devise methods whereby these skills, viewpoints, mental habits, and knowledge can be acquired by the student, through the resources available to the school, with the least expenditure of student time and energy, and with the maximum of effectiveness.

7. *Relation of Schools to Each Other*

a) Professional schools need to work together, because they have common problems which no one school can solve alone.

b) In planning the field of work which its own courses are to cover, the professional school should take into account the work being done by other schools in the same profession so that the needs of the public may be met, excessive duplication avoided, and the education of its students rounded out.

c) The schools of any given profession should come to an agreement as to what should be included in the basic preparation for practicing the profession. If it has adequate facilities, any given professional school may properly offer both undergraduate basic preparation and graduate specialized preparation. Specialization, however, should be built upon, not offered in place of, the basic course.

8. *Relation to the Public and to Other Professions*

a) The professional school serves the interests of its particular profession, but also, and more fundamentally, it serves the interests of the public. It must, therefore, make special provision in its form of organization for keeping in close and constant touch with the public it is to serve. Where professional schools seek only to serve the interests of the profession, and are out of touch with the community they ought to be serving, they tend in the long run to pervert the profession itself. Somewhere on the governing board or on the advisory committees, or through some other mechanism, every true professional school should make provision whereby the demands of society upon the profession, and therefore upon the school, may become articulate.

b) Where any considerable fraction of the members of one profession are employed in close contact with the members of another profession, the schools of each should secure representation from the other, either on their faculties or on their controlling or advisory boards.

For the type of professional nursing described under these eight points, it is clear that special endowments will be necessary. Hospital funds for the cure of the sick or for the apprentice labor of students would not constitute sufficient financing. In addition to the tuition which all students in a professional school should pay, educational endowment by the community is necessary. Tax appropriations have been provided for the training of physicians, lawyers, engineers, and other personnel considered essential for public welfare. Similar support should be obtained for nursing education.

It is this lack of understanding on the part of the public that schools of nursing need financial assistance that has long been a great handicap to advancement in nursing education. Until financial support is received either through public appropriation or private endowment, schools of nursing will not be conducted on an equal level with schools preparing for other professions.

The Grading Committee has been able to describe what most schools of nursing are like and to suggest improvements on the basis of a survey of 1,383 schools of nursing conducted from January through October, 1932.

Most schools of nursing are controlled by hospitals, and most of these hospitals are approved by the American College of Surgeons. The com-

mittee believes that every hospital which maintains a nursing school must meet the minimum requirements formulated for hospitals by medical and hospital organizations.

A nursing school should never be regarded merely as a department of the hospital, which is a natural tendency where the school is wholly controlled by the hospital. It should be remembered that the training of nurses is an educational enterprise and should be conducted as such.

To improve schools so that they may be placed on a professional basis, the committee has recommended to hospitals having schools of nursing:

"*a*) A training school committee.

"*b*) A cost study, to ascertain whether the hospital is losing or making money by having a training school.

"*c*) A budget system, at first perhaps for the nursing service and the school of nursing combined, but as soon as possible for each separately.

"*d*) An arrangement whereby the board of trustees requires the head of the school to be present at board meetings whenever matters affecting the nursing care of patients, and hence, the practical experience of the students, are to be discussed. This arrangement might not be necessary if the training school committee were in real control of the school; but if, as is more probable at present, the committee functions in an advisory capacity only, and the real control is exercised by the board, the head of the school should listen to the discussion, and contribute to it."

It has been found that one-half of all the nursing schools in the United States are conducted by hospitals with not more than 75 patients. The International Council of Nurses recommends that in order to have a sufficient variety in clinical experience, no school should be connected with a hospital which has a daily average of less than 100 patients. If this rule were adhered to in the United States, six out of 10 schools would be forced to close.

It is difficult to find a medical school, a law school, a teachers' college, or even a school of household economics with less than 100 students. Yet the typical school of nursing has an enrollment of only 43 students. There is no denying the fact that the per capita cost of professional education is greater in the small school than in the large one.

Although the committee's survey of 1932 showed that 90% of nursing students were high school graduates, whereas in 1929 only 73% had finished secondary school, still only 43% of the hospitals draw as many

as half of their students from those who are better than average in scholastic standing.

Teachers in nursing schools do not have sufficient educational preparation. Only 27% of nurse instructors in the United States are college graduates. If nursing education is to rank even as high as primary or secondary education, to say nothing of professional education, every faculty member in schools of nursing will have to be a college graduate.

Furthermore, it is impossible to conduct a sound educational institution where most of the faculty remain in the school a shorter time than the students whom they are supposed to teach. Increased tenure is necessary for the quality of nursing service also as well as for nursing education.

Nearly all nursing schools, 91% in the United States, conduct a 36-month course. Particularly sound is the recommendation of the committee that "every school of nursing establish a minimum of four months at the beginning of the student's course, during which time the student shall be on active duty in the hospital for an average of not more than three hours a day, or a total of not more than 18 hours in any week. During the first four months of training, the committee recommends that she be under careful supervision, and that she carry no responsibility for the nursing care of patients."

Most good schools provide some form of affiliation to supplement the training they are able to give their students within their own institution. It is certainly true that except for a very small number of schools, which are able to give training in all clinical services in their own hospitals, schools which desire to prepare their students adequately for practice as trained nurses after graduation must arrange for affiliation for their students.

Schools of nursing have improved in requiring health examinations for their students, not only upon entrance but in their second and third years of training as well. There is still need for emphasis upon this work, however, so that hospitals can be sure that graduates are in as good health as they were when they first entered as students.

None of us can deny that the nurse probationer is probably the most overworked student in any profession. They should not be treated as full-time workers. In fact, unless class and study time are included, the 48-hour week is too long for student nurses.

The survey of the committee shows that students need more and better theoretical instruction. For a three-year course in training 6,552 hours of practice and 885 hours of theory, as a minimum, are suggested in the Curriculum published by the National League of Nursing Education. The

typical school today gives 134 hours less of theory and 843 hours more of practice than suggested by the League. No other profession expects its students to spend seven hours in practice for every hour in the classroom. In the future professional schools will have to give much more and better theory, and less but better practice.

Furthermore, correlation of theory with practice is vitally necessary. Students should not be taught chemistry in the classroom and never reminded of its applications on the ward. Every school must tie its theory to the student's practice and experience.

The emphasis which nursing lays upon practice and the lack of emphasis it lays upon theoretical instruction are illustrated by general scarcity of classroom space. The typical school of nursing has only the classrooms. Forty-two per cent of the classrooms are so dark that it is necessary to use artificial light even during the daylight hours. Again, 53% of schools hold classes at night despite the fact that the National League of Nursing Education has long been on record as strongly opposed to evening classes.

Added to this deficiency is the sorry fact that actually most of the nursing school text and reference books are not on approved lists. Publication dates run back prior to 1860! A good school must have a good library. Therefore, lists of good text and reference books should be compiled for every subject recommended in the curriculum of the National League of Nursing Education. These lists should be revised from year to year to include new books and drop those no longer desirable.

If classrooms and libraries are deficient, the same cannot be said for living quarters, which compare favorably with student dormitories in women's colleges. The one recommendation is that single rooms be provided inasmuch as adequate rest is particularly necessary for student nurses.

Service	*Months recommended by N. L. N. E.*	*Months spent by typical students*
Surgical and operating room	6	10.3
Medical	4	5.6
Obstetric and delivery room	3	3.9
Pediatrics	3	3.3
Communicable and tuberculosis	3	0
Psychiatric and neurological	2	0
Out-patient department	2	0
Eye, ear, nose, throat, skin, metabolism, other specialties	1	0
Diet kitchen	1	1.6

It has been found that the amount and types of practical training which student nurses receive are largely determined by the nursing needs of the patients. The table gives the length of time recommended by the National League of Nursing Education for each service and what the typical nursing student actually does.

It is obvious that most students spend more time on surgical, operating room, medical, and obstetric service and far less on communicable and psychiatric services than is recommended. And although mental hygiene is considered desirable not only in the care of psychiatric and neurological patients, but in the care of all patients, most students receive little or no preparation in this field. It is for that reason that despite the fact that there is great need for good nursing in mental hospitals, and that there are thousands of graduates looking for work, there is still a serious shortage of graduate nurses prepared to care for nervous and mental patients. This mode of providing practical experience is faulty. Time on each service should be determined by the amount of experience the student needs for good nursing in that service, not according to the number of patients to be cared for.

It is true that "practice makes perfect" but it is also true that the practice of poor nursing will make a poor nurse. Therefore, it is necessary that the practice the student gets on the wards, where she secures most of her actual instruction, be good practice. This depends to a large extent on the teachers provided on the wards. Herein lies one of the most serious weaknesses in schools of nursing today. There are not enough good teachers on the wards. If the teachers are capable, then there are not enough workers, not sufficient time, not nearly enough emphasis on what good nursing is.

Teaching in the classroom is difficult enough. But ward teaching is still more difficult. To meet that situation many hospitals are providing student *head* nurses. Where there are graduate head nurses they do not have time enough to teach students. Such head nurses are likely to become taskmasters, not teachers. The student is so pressed for time that she does not think of good nursing, but only of getting the work done. It is in such situations that bad nursing habits are likely to become ingrained. Such practice certainly does not "make perfect." Good practice would necessitate having qualified supervisors and head nurses, enough nursing time to practice good nursing, a reasonable student hour schedule of work, and facilities with which to nurse and teach.

Certain conditions are found in schools of nursing today which should not be tolerated because they have a damaging effect upon nursing education. The committee has wisely suggested that where such conditions

continue to be found, hospital trustees, nursing school committees, and if necessary, national organizations bring pressure to bear to close these schools. The following rules should be carefully observed:

1. No hospital should have a school unless the hospital is listed on the Hospital Registry of the American Medical Association.

2. No hospital should have a school unless the hospital is approved by the American College of Surgeons. Failure to be approved indicates either insufficient patients or lack of sound administration or inadequate professional background of staff. Such an institution is not able to undertake proper conduct of a school.

3. No hospital should conduct a school which is not accredited by the appropriate state agency such as state board of nurse examiners, and unless all graduating students are eligible for the R.N.

4. No hospital should conduct a school unless it has a daily average of at least 50 patients. Fewer patients do not provide adequate clinical material. In those states where there are no good hospitals having more than 50 patients, a level of 35 may be taken as a first step in elimination.

5. No hospital should conduct a school unless it has a training school committee or some other controlling board whose chief responsibility is the conduct of the school. The school should not be considered merely one of several departments of the hospital.

6. No hospital should conduct a school unless it has at least 4 graduate nurses on the staff. These include the director of the nursing service, the day supervisor or operating room supervisor, the night supervisor, and the instructor.

7. No hospital should have a school unless it employs at least one graduate nurse for every six regular or affiliating students.

8. No hospital should have a school unless it provides an average of at least 3 hours of bedside nursing per patient by students and graduates in a 24-hour day.

9. (a) No hospital should conduct a school unless every nurse who is appointed to a position above the rank of general staff or floor duty nurse and who has been graduated within the past 10 years is at least a high school graduate.

(b) No hospital should conduct a school unless it has at least one full-time instructor.

(c) No hospital should conduct a school unless the instructor is at least a high school graduate. She must be at least as well educated as the students she teaches.

(d) No hospital should conduct a school unless every supervisor and every head nurse is a graduate nurse. Students should not be assigned to positions of head nurses, nor should students be responsible to attendants or practical nurses.

10. No hospital should accept students who have not at least completed a high school education or its equivalent.

11. No school should be permitted to operate if it does not provide at least one health examination under control of its own school physician during the first 4 months the student is in the school.

12. No school should operate which does not provide at least a 4-month preliminary period for its students, during which time students are not assigned to regular nursing duty and do not carry any nursing responsibilities.

13. No school should be conducted which allows its students to work more than 8 hours in every 24, whether on day duty or on night duty.

14. No school should be permitted to assign its students on active nursing service for more than 54 hours of day duty or more than 56 hours of night duty in any one week.

15. Under no circumstances should a school assign students to special duty in the hospital or in the home, where the patient is charged for the service.

16. No school should be permitted to operate unless it maintains a record system showing, from the time of a student's entrance, the amounts and types of theoretical instruction and clinical experience she has had.

17. No hospital should conduct a school whose students cannot become eligible, or grant its diploma to any student who is not eligible, to take the examination for R.N. in the state where school is located.

18. No hospital should conduct a school unless it can provide at least the preparation prescribed by the state board of nurse examiners

It is necessary to recognize that it will take some time before all schools of nursing will be placed on a college professional level. Before that desirable situation exists there will continue to be graduated each year a large number of nurses whose basic preparation is not much better than that of most nurses in the field. The field will become steadily overcrowded and unemployment continue unless vocational readjustments are made and carefully planned, and diversified courses provided for graduate nurses. Such courses should help the graduate nurse find the work for which she is best fitted; they should make up for the deficiencies in her basic training and prepare her to go into those branches of nursing in which there is a shortage of properly trained nurses.

"Refresher courses" might well be provided by many hospitals to include theory as well as practice under the direction of competent teachers. Courses might be offered in caring for the chronic patient; in nurse housekeeping in the home; hospital bedside nursing; and clinical specialties to include such services as medical, surgical, obstetric, pediatric, orthopedic, gynecological, ear-nose-throat, eye, metabolic, neurological, etc. Specialized hospitals could also offer courses which would be of value, as for instance, tuberculosis hospitals, those for contagious diseases, psychiatric institutions. For graduates with an excellent basic preparation, who show promise of developing into skilled supervisors and teachers, courses might well be offered in hospital nursing supervision and teaching. Similarly, courses in hospital administration should be offered to carefully selected graduates who have superior personal qualifications.

These courses for graduates fall into two classifications. In the first group are those offered to meet the present emergency, to reduce unemployment, and fit graduate nurses with a deficient basic training to enter fields where their services are needed. There is one danger which should be mentioned here. Hospitals must not offer graduate courses in exchange for graduate labor. There is danger of such temptation. The purpose of graduate training must constantly be kept in mind . . . the nurses upon completion of their course must be better equipped to earn a livelihood than they were when they enrolled. Therefore, *all* graduate courses must be carefully planned.

The second group includes courses for graduate nurses who possess a thoroughly sound basic preparation. Such courses differ from the first

group in that they would have a definite place in a professional educational plan.

The Committee on the Grading of Nursing Schools has sought to find a means of getting the right nurse for the right patient. Looking first at the other side of the picture, it has been agreed that patients may be poorly nursed for three reasons: (1) nurses have been improperly trained; (2) patients cannot afford to pay for services they need; (3) patients have not been placed in touch with the right nurses.

Concretely, how can these problems be solved? To overcome improper training of nurses, the committee suggests that the work of state boards of nurse examiners be strengthened and extended. It is believed that hospitals generally would welcome constructive professional leadership from these boards in the nursing field. They should make a concerted effort to raise the requirements for professional education of nurses. Furthermore, nurse registration should not be merely permitted; it should be definitely required in each state. It is suggested that studies be made to determine the feasibility of requiring a state license for every school which claims to prepare students to give any form of nursing care for hire. For in this way it would be far easier to establish and maintain respectable standards for nursing education.

Patients cannot afford to pay for services they need. Does that mean that the charge for private duty nursing must be reduced? But private duty nurses do not earn a sufficient annual salary. The answer is that unemployment must be reduced if charges are to be lower. If private duty nurses could be assured of steady employment, their daily charges could be lowered. The daily cost of nursing to the patient should be as low as possible, but the nurses must make a reasonable salary. A plan will have to be worked out in which more flexibility in salaries and service will be provided. What the nurse receives should vary according to what she is able to give and the conditions under which she has to work.

Hospitalized patients could be better served at less cost if they did not have to employ special nurses. The Grading Committee believes that hospitals would be well advised to employ more graduate nurses for general staff nursing since patients would be willing to pay slightly higher daily rates if the charges covered adequate floor nursing.

For the most satisfactory nursing in the home it is believed that the extension of public health nursing and hourly nursing service, which have long demonstrated their value, would be advisable. However, more funds for the support and extension of these services are urgently needed.

In order that each patient might get the right nurse, it is suggested that central nursing bureaus be organized in which carefully selected groups of

private duty nurses might be employed on regular salaries to give private duty nursing in the hospital and in the home on an eight-hour basis. The plan is well worth considering, since it would meet a need for good but less expensive special nursing; it would provide steady employment to a number of well qualified private duty nurses.

Nursing schools as they are organized and functioning today are not providing adequate basic training to fit nurses for the demands of their professional career. A number of weaknesses in the present system have been brought out and suggestions made for their improvement. What is necessary now is organized coöperation among all the groups concerned with caring for the ill and injured. The National League of Nursing Education, organized in 1893, seems the logical body to take steps toward carrying out the activities suggested by the Grading Committee. It is recommended that a permanent Advisory Council in Nursing Education be organized representing the various groups closely concerned with nursing education: nursing, medicine, public health, representatives of colleges and universities, hospitals, and the public. For the health of our people, it is vitally essential that improvement be made in nursing education. Such a council could be most effective in achieving the necessary reforms.

What Is a Hospitals Centre?

Shortly, a Hospitals Centre is an economic and logical coöperation of effort and coördination of hospitals and health facilities. Physically, it is a hospital or group of hospitals linked with the medical faculty of a university. It may be said to have four main functions: (1) treatment of the sick (medical function); (2) training of medical students and nurses (teaching function); (3) investigation (research function); and (4) constructive health building (social function). The advantages of such concentration are obvious. It is equally obvious that it is neither practicable nor economical for any one or more scattered hospitals to accept the obligations of this four-fold responsibility. The object of a Hospitals Centre is to get organized team work as opposed to isolated effort. With the modern development of specialization on intensive lines, there is a regrettable tendency for the specialists to become isolated into groups; in a Centre, all the specialists are accommodated in a comprehensive group, and the work of training medical students and nurses together with that of investigation (research) go on concurrently with the treatment of the patient.—*From the Official Journal of H. O. A. (Inc.), Great Britain.*

Voluntary Hospital Insurance in England

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IN PLANNING my address I have endeavored to explain:

a) The changes which occurred in the financial position of the British voluntary hospitals, consequent upon the changed economic conditions resulting from the European War, and the reasons which necessitated the change in their methods of obtaining annual revenue.

b) The purpose of Voluntary Hospital Collecting Funds which were strengthened to meet the new post-war conditions.

c) The results which have been achieved by this new method of hospital finance.

d) The problems which have been created, and the difficulties which have yet to be surmounted.

THE POST-WAR SITUATION

With the changed economic conditions resultant upon the War, the voluntary hospitals found themselves facing an entirely new set of conditions. The costs of every commodity, especially drugs, dressings, and medical equipment, had considerably increased. The community was found to be making increasing demands upon the services of hospitals. With an annual deficit of four million dollars, the voluntary hospitals were forced to make good these deficits by utilizing legacies which prudent treasurers would have preferred to invest for endowment or utilize for capital purposes, and further to resort to borrowing from the banks. Charitably disposed persons no longer possessed the same financial reserve as formerly and found themselves compelled to curtail their subscriptions to voluntary hospitals. The new rich had not yet learned to use their newly acquired wealth in community service. The hospitals found themselves facing a very uncertain future. What was to be done?

A commission appointed by the British Government, under the chairmanship of Lord Cave, to report on the problems of voluntary hospitals, made the following important recommendations:

a) That it will in many cases be desirable, in order to avoid competing appeals by different hospitals, that organized collections

*Condensed from an address delivered before the 36th annual convention of the American Hospital Association, Philadelphia, September 27, 1934.

(i.e., contributions from wage-earners) should be made by some central body, such as a Regional Voluntary Hospitals Committee, on behalf of all the hospitals in the area, and should be distributed among the hospitals on some agreed basis.

b) That these weekly contributions should not give the wage-earners any claim to priority of treatment—admission to hospital to be determined on medical considerations only.

c) That it is essential to the success of the scheme that the contributing workmen should be given suitable representation on the governing bodies concerned.

About six and a half million employees are contributing regularly to the voluntary hospitals, representing (with their wives and children) about 15 million people. On June 25, 1934, there were 10 million employed persons compulsorily enrolled under National Health Insurance in England, and as the voluntary hospital contributory funds mainly include persons insurable under the National Insurance Acts it will be seen that about two-thirds of the compulsorily insured population of the country are also entitled (with their dependents) to receive free hospital maintenance as a right rather than be recipients of charity.

THE DEVELOPMENT OF VOLUNTARY SCHEMES

It was my privilege to be responsible for one of the earliest organized efforts to establish a contributory fund among employers and employees in Sheffield in the year 1921. Notwithstanding a decade of unprecedented industrial depression, 200,000 employees have been enrolled into a regular weekly contributory fund in that locality. A further experiment in the centralization of hospital policy and hospital finance was commenced under my direction in 1927 on Merseyside, which includes the City of Liverpool, the County Boroughs of Bootle, Birkenhead, and Wallasey, and their immediate environs, a total area of about 250 square miles. In 1933, the Merseyside Fund had enrolled over 274,000 contributors. In some communities the contributors comprise almost the entire laboring population. For example, in Birmingham 450,000 contributors with their families are enrolled. The growth of the Hospital Savings Association of London deserves special record. Formed in 1923, the income of 1925 was $340,000 from 160,000 contributors. Ten years later the income rapidly grew almost tenfold to $3,200,000 with over one and a quarter million contributors. The Prince of Wales is patron of the London Association and the King's physician is its vice-president. The Association prints a substantial monthly magazine as its house organ.

In the London organization some of the members join through their place of employment, but the majority, as in several other cities, are

organized into groups. Each group has a "secretary" whose duty it is to stimulate interest, adjust minor difficulties and collect payments. The "group secretaries" serve voluntarily, and are especially active among contributors who do not contribute through their places of employment, but as individuals through their secretaries, who in turn pay the proceeds to the association.

Another type of adventure with special interest is illustrated by the London, Midland and Scottish Railway Employees' Hospital Fund created and conducted entirely by the interested and enthusiastic labors of railway directors and employees. Started in 1921, an annual income has been built up amounting to $877,800 from about 250,000 employees of this British railway in the interests of hospitals.

VALUE OF CONTRIBUTORY FUNDS TO VOLUNTARY HOSPITALS AND COMMUNITY

The estimated average amount paid by English contributory funds to the voluntary hospitals is about $10 a week, equal to about 70 per cent of the actual cost of maintenance. This does not, of course, reimburse the hospitals for their services. But when one considers that English workmen as a class paid considerably less than half the costs of services received before the contributing schemes were introduced, the voluntary hospitals may be regarded as profiting by the new plans. There is a growing consciousness that English contributory funds must accept an obligation of meeting the full cost of maintenance of contributors in voluntary hospitals. A few schemes have done so.

The Oxfordshire Contributory Scheme has always succeeded in making a payment to its voluntary hospitals of $17.50 per week per *in*-patient contributor hospitalized. The Woverhampton Fund meets the entire costs of hospital service to contributors and leaves a generous surplus toward the annual cost of treatment of its local sick poor.

THE USE OF GOVERNMENTAL HOSPITALS BY CONTRIBUTORS

The Management Committees of the large contributory funds in England have catered to the needs of contributors by admitting them to publicly owned hospitals. The Local Government Act of 1929, which came into operation in 1930, gave powers, for the first time, to public authorities in England to provide general hospital treatment for the community. Prior to that date general hospitals were owned by the Boards of Guardians under the Poor Law Acts, and could be utilized only by certified indigent patients. The admission of contributors to publicly owned hospitals was necessary in many of the large industrial areas, such as London, Birmingham, Merseyside, and Sheffield, where the voluntary

hospitals have been unable to provide the heavy capital costs of the additional general hospital accommodation needed by the community.

Family doctors frequently arrange for the admission of contributors into publicly owned hospitals for the treatment of acute illness. The contributory funds make arrangements with public authorities for their contributors to be exempt from—(a) investigation into their financial circumstances, and (b) payment or charge of any kind.

Voluntary hospitals owe a great debt to the public authorities for their ready and friendly coöperation in regard to the establishment and conduct of contributory funds. The payment asked by public authorities from voluntary hospital contributory funds toward the cost of maintenance of a contributor in a public hospital is approximately the same weekly amount which the average workman could afford to pay to public funds if no voluntary hospital contributory fund existed.

The persons eligible for participation in the contributory schemes for the most part are those who come within the national health insurance income limit. The official policy of the British Hospital Contributory Schemes Association is that all persons within the national health insurance income limit should ultimately subscribe, and that the total amount of their subscriptions should be sufficient to meet the full cost of maintenance in a voluntary hospital. The full cost ultimately should include a reasonable payment for the services of a practitioner to treat these patients.

Two important groups are not now subscribing to the contributory schemes and are not really eligible for their benefits. The first is the well-to-do, a relatively small group of private patients who use private accommodations and who are willing and able to make payment from their private fees. The other group is the unemployed and sick poor whose financial circumstances are such that they are able to make little or no contribution when they are well or when they are ill. The costs of this group are met by charitable subscriptions in voluntary hospitals and by taxation in public hospitals.

THE BRITISH HOSPITAL CONTRIBUTORY SCHEMES ASSOCIATION

There are approximately 150 contributory schemes in England, and nearly every voluntary hospital participates in the benefits of a contributory fund, either as a single institution with a limited number of subscribers, or as one of a group of hospitals serving an entire community. The larger funds hold membership in the British Hospital Contributory Schemes Association, which included about 130 schemes with about 6,000,000 contributors in 1934. At the annual conference in 1933 more than 100 representatives from 45 different schemes were in attendance.

The secretary to the association acts in an advisory capacity to the officers of local schemes, coördinates the activities of the various funds with the interests of other professional groups, accumulates statistics for comparative purposes, advises on the development of reciprocity between funds, and conducts a clearing house for the exchange of information.

ATTITUDE OF THE BRITISH MEDICAL ASSOCIATION

The contributory schemes have been developed for payments to hospitals, and consequently they have not directly affected the private practice of physicians. However, the British Medical Association has taken an active interest in administration of the plans, and has coöperated actively in maintaining a high standard of professional services for contributors who previously had sought their hospital and medical care as recipients of charity.

The value of the insurance principle in the payment of hospital bills has been officially endorsed by the British Medical Association. As the original contributory schemes have come nearer to paying the full costs of medical care, the doctors have asked, and rightly so, that a portion of the contributors' funds be used for the reimbursement of attending physicians and surgeons.

At the 1933 annual meeting of the British Hospital Contributory Schemes Association two official representatives of the British Medical Association participated in the program and advocated extension of the contributory scheme to the middle classes. Dr. Peter McDonald, chairman of the Hospital Committee of the British Medical Association, said among other things at that time:

"My association has had it brought home that serious illness, especially illness involving attention in nursing homes or in pay beds at hospitals, imposes a breaking strain on persons of moderate incomes.

"It is at present exploring the possibilities of the establishment of Provident Schemes, or of the extension of the relatively few and small existing Provident Schemes, whose object, or chief object, will be to pay for persons who have to go as in-patients to pay beds at hospitals or to nursing homes. . . . This has not yet been made a part of the policy of my association, but . . . I have great hopes—indeed, confident hopes—that the sort of thing I am indicating will at an early date meet with the approval of my association and with that of the surgeons and other practitioners concerned."

At the annual meeting of the British Medical Association, July, 1934, the profession decided to approve a model hospital scheme adaptable to any area for the provision of hospital services on a contributory fund principle for persons of moderate means. This recently approved con-

tributory fund includes married men with incomes of £500 or $2,500 per year and unmarried men with incomes of £350 or $1,750 a year. The fund makes payments on behalf of each patient for nursing and maintenance of $25 per week for a maximum of three weeks and a payment to the physician or surgeon averaging $80 for each case. These are inclusive charges, no further fee is payable by the contributor or by the fund.

INCOME LIMITATIONS UPON SUBSCRIBERS TO CONTRIBUTORY SCHEMES

As previously stated, most of the contributory schemes have not been financially self-supporting; consequently, there has been a tendency to limit the benefits to people of small incomes. The contributors receive free care from the attending staffs of the hospitals, although procedures are in effect in some places by which members of the hospital staff are paid from the contributing funds. The British Medical Association has for many years urged that only persons within certain income limits should be entitled to the free hospital privileges of organized contributory funds.

A few of the older contributory funds have not established income limits, but the larger and more recently established funds, notably the Hospital Savings Association of London, and the Merseyside Contributory Fund, have adopted the limits of income urged by the British Medical Association, which are essentially as follows:

Unmarried persons without dependents	£4 or $20 a week
Married couples without dependents	£5 or $25 a week
Married with a dependent	£6 or $30 a week

The regulations of the Merseyside Fund require that a contributor must bring an explanatory note from his family doctor except in cases of casualties and emergencies. The British National Health Insurance Act provides for the services of general practitioners, but does not cover specialists' services or institutional care for insured persons. Nor does the national plan provide any services whatever for dependents or insured persons. Consequently many voluntary hospitals provide much medical and surgical service to the families of the lower paid wage-earners who for economic reasons may be prevented from purchasing such services from a medical practitioner. A certain number of dependents of contributors apply for general medical services at the out-patient departments of the participating hospitals in the contributory schemes. This fact gave rise to the requirement of the certificate from the family doctor.

A dependent is defined by the Merseyside Hospitals Council Contributory Fund as a "relative resident with and wholly dependent upon the earnings of the contributor."

RATES OF CONTRIBUTIONS AND HOSPITAL BENEFITS

Weekly contributions vary from one community to another. Some of them are organized on a uniform basis, some of them as a proportion of the wage system. Where they are established on a uniform basis, the usual arrangement is 3d. per week, with the possibility of an additional penny a week paid by the employer himself. The rate of 3 pence is applied in Birmingham, in London, and for the railway system previously described. In Oxford the contributory scheme is at the rate of 4 pence per week. In Sheffield and in the Merseyside Hospital Council the plan of one "penny in the pound" is used, with an additional penny a week from the employer.

Contributors are entitled to hospital benefits when they present a hospital "voucher" placed in their hands by their employer, or a "group secretary." Admission may be obtained only on recommendation of a practicing physician, but without the possession of the "voucher" a subscriber is not eligible to the *free* services of the plan. The benefits received by contributors are as follows:

1. In-patient service.
2. Out-patient service, except that more than one call may not be made without special recommendation of the attending physician or family doctor.
3. Convalescent and after-care.
4. Special treatment for rheumatism and like diseases.
5. Extra nourishment (eggs, milk, butter, etc.) for a period of six weeks.
6. Surgical appliances.
7. Assistance to mothers in times of acute illness. The council will look after the home while the mother is away or will place children under suitable care.
8. Financial assistance and clothing.
9. Home visits by home visitors.
10. Motor transport by voluntary car owners during the night hours for relatives of dying patients and for blood donors.
11. Ambulance service.
12. Home nursing on the recommendation of a practicing physician.

The contributory funds themselves accept no responsibility for certification for admission. The decision as to whether or not there should be immediate admission to a voluntary participating hospital is in the hands of the family doctor and the hospital doctor.

The English contributory schemes accept the responsibility of payment only for such cases as would be medically eligible for admission to

a voluntary general hospital. Through public funds and through state and municipal hospitals, the Government has accepted the responsibility for certain other types of chronic and long-stay illnesses. For this reason there is excluded from the British contributory schemes treatment of such conditions as tuberculosis, mental disease, infectious disease, senility, chronic and incurable diseases, and illnesses dealt with by school clinics, such as treatment for tonsils and adenoids, ringworm, and eye testing.

ORGANIZATION OF HOSPITAL CONTRIBUTORY FUNDS

The contributory schemes are usually organized on a community basis, as civic movements under the sponsorship of many important agencies. A "council" guides the activities of collecting funds from subscribers and making payments to the participating hospitals. Usually there is free choice not only among participating institutions but voluntary hospitals everywhere.

An illustration of the agencies represented in the administration and control of a contributory scheme may be taken from that of the Merseyside Hospitals Council which contains representatives from the following groups: hospital management boards, hospital medical staffs, employers, organized labor, churches, universities, municipal hospitals, and other agencies. The administration of the council controlling the contributory fund is carried on by a group of committees, each one under the supervision of the executive secretary of the council, who is a full-time employee. These committees include those for general purposes, finance, hospital organization, ambulance, distribution, extension and publicity, convalescent and after-care, hospital Sunday appeals committee. The council's administrative staff is made up of a group of departments, each with its own appropriate clerical staff for secretarial work, accounting, ambulance transport, publicity, and convalescent and after-care, etc.

When collections of funds are made through payroll deductions, the employer of labor participates greatly in making the plan a success. The activities of the labor employer in connection with a fund include the following: (1) giving facilities to the council's staff to meet and address employees; (2) collecting employees' contributions at the rate of a penny in each pound (or some agreed amount) of their earnings through the wage offices; (3) making an annual subscription (in over 90 per cent of the firms) equal to one-third of the total contribution; (4) sending the contributions at regular intervals to the central fund; and (5) issuing free hospital vouchers for in-patient and out-patient service to contributing employees and their bona fide dependents.

In Liverpool, the original contribution of one penny in the pound has

not been sufficient to cover the whole cost, due to the low rate of contribution.

METHODS OF COLLECTING

The most productive and economical plan of collecting hospital contributions has been to ask the employer to collect them from the wages or salaries of the employees. Under any alternative scheme of collection it is unlikely that as many persons would be enrolled, although in non-industrial communities astonishingly large numbers of contributors have joined "groups" and made their contributions through group secretaries.

Arrangements have been made in most of the contributory schemes to take care of unattached contributors who cannot contribute through employers, such as domestic servants, individual craftsmen, assistants in suburban shops, and state pensioners. These individual contributors are asked to pay a larger rate because of the absence of the employer's contribution. They are also required to wait some months before they are entitled to any of the free hospital privileges. The first provision reduces the overhead costs of taking care of a large number of contributions. The second avoids the difficulty of adverse selection from individual subscribers who might expect to receive hospital care shortly after their enrollment.

Usually no person employed in an establishment of 10 employees or more is allowed to become an individual unattached contributor. In such cases, the employer is persuaded if possible to operate the fund officially from the place of employment.

There is a careful selection of approved, well conducted shops which act as receiving depots for contributions from unattached contributors. There are 480 of these receiving depots in Liverpool and the Merseyside district which receive payments from 40,000 individual contributors as a voluntary service without payment of any kind. Each shop is given a six weeks' supply of stamps and each contributor is supplied with a separate contribution card. When he makes his weekly or monthly contribution to the depot, he receives stamps which are affixed to his card.

SUGGESTED CHANGES IN THE EXISTING PROCEDURES

There is some question as to whether or not it is desirable to include out-patient service in the benefits of the hospital contributory scheme. Likewise the question may be raised whether it is appropriate to include maternity care in a contributory plan of this kind. At the present time in England every employed woman and the wife of every employed man can secure a grant of two guineas from the National Health Insurance fund for the costs of childbirth which partly meets the cost for the average wage-earner for maternity care in English hospitals.

Certain problems remain in the plan. One is the financial payment of hospital medical staffs. This is gradually being solved by the raising of contributions, and the establishment of provident schemes for the middle classes. Another is the coördination of hospital services among the various institutions in the community, not only voluntary but publicly supported municipal institutions. Such coördination requires both tact and administrative ability. Reciprocity between different contributory funds is becoming the rule rather than the exception.

SUMMARY AND CONCLUSIONS

There are at the present time in Great Britain over six and one-half million subscribers to British Hospital Contributory Schemes who with their dependents comprise approximately 15 million individuals, assured of hospital care in case of necessity without additional cost to themselves.

Up to 1920 workmen or people of limited means and their families were accustomed to receive hospital care in public hospitals or in private voluntary hospitals and were expected, if possible, to make some voluntary contribution at the time of their discharge after receiving hospital care. It was customary also for individual hospitals to make drives for funds through small contributions from larger numbers of people as well as large contributions from the well-to-do. Consequently, it was decided to make a systematic canvass of the employees of each community, asking them to make regular contributions and guaranteeing them in return hospital care if necessary without special financial investigation.

It was not originally intended that the subscriptions from the workmen and people of limited means would suffice to cover the costs of hospital care that they would receive. It was felt, however, that the contributions received in this way would be much greater in total than the meager voluntary contributions made by these people at times of hospital illness. The British Hospital Contributory Schemes were not primarily "insurance plans" for distributing the cost of medical care among people accustomed to paying hospital bills at the time of their sickness.

Large numbers of employed persons are unable to meet any or more than a fraction of the cost of hospital care at the time of an acute illness. The experience of the schemes indicates clearly that these same persons can contribute to a plan of "group budgeting" which pays a substantial share of the costs received by those in the groups requiring hospital care.

The hospital contributory schemes are officially and enthusiastically endorsed by the British Medical Association, which also recommends that self-supporting plans for the "middle classes" be adopted throughout the country.

Experience of a Hospital for People of Moderate Means

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THE BAKER MEMORIAL, the department of the Massachusetts General Hospital for patients of moderate means, has now been in operation for four and a half years. During that time, while hospitals throughout the country have seen a decline in the use of their facilities for pay patients, the Baker has cared for an increasing number each year—1,973 in the 10 months of 1930, 3,244 in 1931, 3,425 in 1932, 3,693 in 1933. In the nine months of 1934 which have elapsed there have been 3,306 patients admitted—or at the rate of over 4,000 for the year.

Under the title "The Middle-Rate Plan for Hospital Patients" the Julius Rosenwald Foundation has published two excellent reports on the first and second years' experiences of the Baker Memorial, including in the latter a study of the patients admitted and a report of the attitudes of Boston physicians toward the Baker Memorial. Dr. C. Rufus Rorem in these reports summarizes the principles of the Baker Memorial plan as follows:

"1. Offering moderate rates for bed care and for special services in a hospital unit large enough to facilitate economical administration.

"2. Arranging coöperation with the medical staff whereby moderate fees are charged for professional services.

"3. Unifying, by consent of the medical staff, all financial dealings with the patient under the hospital administration, so that the patient is not presented with two or more independent bills for hospital and professional care respectively, but with a single bill, collected by the hospital, which in turn passes over to the physician his agreed fee.

"4. Endeavoring to minimize the amount and the costs of special nursing.

"5. Seeking to provide all the service at cost, without charity and without profit."

The rates charged at the Baker Memorial are designed to cover the cost of service when the unit is occupied to about two-thirds of capacity. This occupancy has not yet been reached, and costs have not so far been met.

The rates per person per day are:

In single room	$6.00	(single room with toilet $6.50)
two-bed room	5.00	
four-bed room	4.00	
nine-bed ward	3.45	per day or $24.00 per week

The laboratory fee is $10—this is not charged when there is an operating room or delivery room charge. The operating room fee is $15 for major operations, $10 for minor operations. The delivery room fee is $15. The fee for general anesthesia is $5. X-ray charges range from $5 up, depending on the number and type of examinations or treatments—no patient is charged more than $50 for x-ray service.

A sufficient number of floor nurses is provided so that special nursing is seldom necessary. The average number of nurses assigned to floor duty provides a ratio of one nurse to three patients—about 80% of these are graduates. Special nurses are provided only if the patient needs more care than can be given by the regular floor service, and only with the consent of the attending physician; they are not allowed merely as a luxury. About 15% of the patients have special nursing during part of their stay, the majority of these for only two or three days following a major operation.

Patients may be cared for at the Baker Memorial only by members of the Massachusetts General Hospital Staff (including the staff of the Massachusetts Eye and Ear Infirmary). The staff numbers over 200.

The staff have coöperated in the Baker Memorial plan by voluntarily agreeing to limit the fees charged for their services to patients in this department. The maximum fee which may be charged for any one case during a single stay in the hospital is $150, regardless of the length of the stay or the number of physicians involved. A fee schedule was prepared by a committee of the staff, with charges for various services ranging from the maximum for difficult major operations down to very small charges for minor services. Calling for fees of $100 to $150 are: operations on the brain and spinal cord, stomach and intestinal resections, prostatectomy, extensive gynecologic and orthopedic operations, radical operations on the mastoid and sinuses, difficult eye cases. For the less difficult major operations the fee is $75 to $100—in this group are: appendectomy, repair of hernia, simple mastoid, plastic operations on the perineum, closed reduction of major fractures. In the group of minor operations, with fees from $25 to $50, are: D. & C., tonsillectomy, hemorrhoids, reduction of minor fractures. For special technical procedures, such as cystoscopy, paracentesis of the body cavities, lumbar puncture, refraction, and for small operations, the fees range from $10 to $25. For obstetrical cases the normal delivery fee is $100, for cesarian section $150. For medical care or study the fee is $25 to $35 a week. Consultations are charged at $5 each. In cases where more than one doctor is involved and the total of the individual fees would normally exceed the maximum of $150, the amount allowed to each is prorated, with the exception of single consultations, for which the $5 fee is not reduced.

The staff have also agreed to have the hospital set the fees in each individual case, in accordance with the fee schedule and with the patient's circumstances, and to have the hospital collect the fees for them. The professional fee is made an integral part of the hospital bill, the whole being regarded as a single obligation payable to the hospital. Our record

of collections indicates that many patients pay the hospital more promptly than they do their doctors if billed separately.

The staff having agreed to accept limited fees from Baker Memorial patients, the hospital undertakes to see that only patients of moderate means, who cannot afford to pay higher fees, are admitted. We have no exact definition of what constitutes moderate means, as there are factors other than income to be considered, such as family obligations (number of dependents, children in school or college), debts, probable length and cost of the illness, previous expense for illness, loss of income because of illness. On admission every patient, or the person responsible for the bills, is asked to state the family income, the value of property owned or the amount of rent paid, the number of dependents, the bank resources, and the amount of life insurance carried. All information given is treated as confidential and in practically all cases is accepted at its face value. Only if we have reason to believe that the financial position has been understated in order to gain admission, do we get a financial checking from a credit bureau.

If it seems from the information given that the patient is above moderate means, he is asked to enter the Phillips House, or if he prefers, to arrange for admission to some other hospital. If it appears that he cannot afford to pay the Baker Memorial charges, he is advised to enter the wards of the General Hospital. In either case the doctor who referred the patient to the hospital is consulted and the reasons explained to him. Contrary to what one might expect, there are many more requests for admission to the Baker Memorial from patients who cannot afford it than from those who can afford to pay higher fees.

One hundred consecutive admissions during May 1934 were reviewed. Of this group we had definite information regarding the incomes of 70. Of the other 30, eight were physicians or members of their families, or graduate nurses; seven were retired or unemployed and living on savings; the balance could not state their incomes definitely—some were proprietors of small businesses which they stated were operating at a loss.

For the 70 who stated their incomes, the distribution was as follows:

Less than $1,000 per year	9
1,000 to $1,500	14
1,500 to 2,000	15
2,000 to 3,000	19
3,000 to 4,000	8
4,000 to 5,000	none
5,000 and over	5

The average income of the group was $2,272. Eighty per cent had incomes less than $3,000, 54% less than $2,000. If we add those who were

living on savings, and those whose businesses were losing, the proportion of small incomes is even higher. Previous income studies have yielded essentially similar figures.

The great majority of the patients are sent to the Baker Memorial by members of the hospital staff; how many of these may have been referred to the staff for admission to the Baker we have no records to indicate. Of 3,300 admissions during the first nine months of 1934, only 96, or 3%, were referred directly to the hospital by non-staff physicians. For many of these the referring physician designated a staff member whom he wished to have take care of the patient. We have definite record of only 42 as having been sent to the hospital without designating a member of the staff, but as we have not kept accurate record of this during the entire year the number is undoubtedly somewhat higher, but can hardly be more than 2% of the total admissions. The occasional patient who requests admission without reference from a physician we do not as a rule admit directly. Such patients are asked to consult their local doctors and request recommendation for admission from them, or if they have no regular physician they are given the names of several members of the staff and advised to consult one of them.

Financially, the Baker Memorial has not as yet been able to pay its way. There has been a large annual deficit averaging $63,000 a year for the four years the unit has been in operation, without allowing for interest on the investment or depreciation of the equipment. It was realized before the building opened that it would be several years before it would be operating at sufficient capacity to be self-supporting. The Julius Rosenwald Fund of Chicago, which has been interested in plans for lowering the cost of medical care to people of moderate means, agreed to pay half the deficit for the first three years, such payment not to exceed $75,000 in any one year nor $150,000 in all. In figuring the deficit we were allowed to include a substantial charge for depreciation of the equipment of the building, but even so we were not obliged to call on the Rosenwald Fund to the full extent of their promise. Because of financial reverses attendant on the depression the Fund has been unable to extend the commitment beyond the three-year period, and the charitable funds of the Massachusetts General Hospital must carry the deficit until increased occupancy of the building wipes it out.

The Baker Memorial has an eventual capacity of 325 beds. For the first four years 189 beds were available for Baker Memorial patients. In the spring of 1934 another floor was opened, increasing the capacity to 226. The greatest number of patients at any one time has been 204, and the highest monthly average 180—both in May 1934. The average for the year 1933 was 133. For the first nine months of this year it has been 155.

The deficit this year has been substantially less. It is expected that with an average occupancy of about 200, or a little less than two-thirds of capacity, the building will be self-supporting.

Prior to August 1932 the rates charged for board were for nearly all accommodations 50 cents per day higher than at present. The schedule was:

All single rooms	$6.50 per day
two-bed rooms	5.50
four-bed rooms	4.50
nine-bed wards	4.00

A reduction in rates was made at that time in order to pass on to patients of the group we intended to serve some of the benefit the hospital was receiving from lower prices and lower salaries. The income from patients would have been considerably greater during the past two years had the reduction not been made, provided of course we had had the same number of patients under the old rates that we actually did have under the new. For the year 1933 the difference would have been about $24,000.

Collections have been very good. Of the 100 cases reviewed, 67 paid their bills in full on discharge, 16 paid within 30 days after discharge, and only 11 had an unpaid balance three months after discharge—of these all had paid in part, and had given notes for the balance.

For the four years ending February 28, 1934, the total receipts from patients were $2,230,000, of which $1,450,000 was on account of the hospital (including $160,000 for special nurses), and $780,000 was on account of the doctors.

Against total receipts of over two million dollars, we had unpaid accounts amounting to $64,000, or about 3% of the amount charged. Of these $32,000 were carried as accounts receivable and $32,000 had been charged off as bad debts—these latter accounts were for the most part over a year old, and represent about 2% of the charges for the first three years.

It is interesting to note that the two periods of greatest occupancy experienced by the Baker Memorial have coincided with periods of increased activity in the business world. The first was in June and July of 1933, when the New Deal was first getting under way. The collapse of the boom in midsummer was followed by a decline in the occupancy of the Baker Memorial. With the increase in business activity in the late winter and spring of 1934 the occupancy of the Baker Memorial again rose, this time to the highest levels so far experienced. This year has shown a higher occupancy during every month than in any previous year. This experience would seem to indicate that with a return to more normal economic conditions the Baker Memorial will be able to pay its way.

Central Supply Room versus Sectional Supply Service

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As in all new ventures, there were many difficulties to overcome and problems to solve. There was the question of economy and efficiency. With reduced hospital incomes, there was the need of the minimum amount of equipment giving the maximum amount of service. There was also the need of making it possible for a reduced nursing staff to give the patients the best possible care. To accomplish this, some detail work had to be taken from the nurse to allow her more time for bedside care. At this period there was increased demand for intravenous and hypodermoclysis solutions and equipment.

In our hospital, as in many others, one of the operating room supervisors was responsible for teaching and directing a student nurse in the preparation and sterilization of solutions. The Kelly flasks, tubing, and needles were cared for on the halls under the direction of various head nurses. These articles were wrapped and sent to the operating room for sterilization, later to be called for by a messenger from the hall. Not every hall had space, personnel, or material to properly do this important work as outlined by the pathologist. To meet these needs, the central supply room had its beginning.

SITUATION

Not all hospitals are built with space available to meet the needs of an ideal central supply room, but, with careful planning and adjusting, some space can be arranged to be utilized for this work. Such a room should be near the gauze or surgical dressing and sterilizing room. It should be situated in the center of the building near the elevators and, if possible, should have dumb-waiter service. A house telephone is needed.

PERSONNEL

One experienced supervisor should be in charge of dressing, sterilizing, and central supply rooms. The supervisor should also be responsible for the instruction of the students in the care and use of equipment and the preparation of surgical supplies. With teaching and supervision, lay workers may be trained to become very satisfactory workers in this department.

THE ROOM EQUIPMENT

The central supply room should be well lighted and equipped with:

1. Cupboards and shelves to accommodate treatment trays, surgical equipment, and sterile supplies.
2. Sink with drain board at either side.

3. A good water suction for proper cleansing of tubing, catheters, etc.
4. Long work tables and small cart tables.
5. Rack for drying tubing and rubber goods.

SALINE AND SOLUTION ROOM

Two sinks and drain board for washing solution flasks
Autoclave for solutions
Two water sterilizers
Sterilizer for boiling equipment when necessary
Work cabinet with built-in shelves
Gas plate
Dripping stands for saline
Water still, unless the laboratory has sufficient supply of freshly distilled water and is in close proximity.

In the central supply room are kept the following:

Arm bath
Atomizers
  Nasal
  Tannic acid
Adhesive
  Moleskin
Applicators, sterile
Adaptors, glass, sterile
Anoscope
Antrum syringe
Bandage
  Ace
  Alexander
  Ready
Beakers, sterile
Brushes for tracheotomy tubes
Breast pump
Bed blocks
  Low
  Medium
  High
Bags
  Hot water
  Ice
  Spinal ice bag
Bed guards, North
Bottles
  Blow
  Sterile specimen
Boxes
  Intravenous
    Harper
    Continuous
    Baxter
  Hypodermoclysis
  Blood chemistry
  Gastric analysis
  Gastric lavage
  Spinal puncture
  Bile drip
  Dakin
  Pneumothorax
Communion box
Croup tent
Cradles
Catheters
  Female
  Male, No. 8, No. 24
  O.E., No. 14, No. 24
  Mushroom, No. 18, No. 36
Cans, irrigating
  Claritor
  Chemical heating pads
Covers
  Drainage bottles
  Hypodermoclysis flasks
Drains
  Mastoid
  Flat rubber, cigarette

- Eye tray
- Eye cup
- Emergency hemorrhage set
- Electric heating pad
- Electric stoves
- Feeding cups
- Funnels with tubing
  - Rectal anesthesia
  - Rectal feeding
- Feathers for tracheotomy tubes
- Gloves
- Hand and foot ties
- Ice collars
- Linen
  - Sterile for burn cases
  - Muslin, sterile, for burn cases
- Lamb's wool applicators for tracheotomy tubes
- Laryngeal mirrors
- Morgue rolls
- Packings
  - Iodoform, 1-inch
  - Iodoform, 3-inch
  - Mastoid
  - Nasal tape
- Perineal pads in containers, sterile
- Pelvic traction girdles
- Pelvic hammocks
- Pneumothorax
  - Davison machine
- Pneumonia jackets
  - Dr. Cooksey's jacket
- Rubber aprons
- Rubber protectors, large and small
- Rubber silk
  - Sterile
  - Unsterile
- Restraining sheet
- Rubber ring
- Solutions
  - Sterile boric
  - Sterile saturated solution saline
  - Sterile normal saline
  - Sterile distilled water
  - Sterile novocaine 2%
- Sand bags
- Suctions
  - Prostatectomy suction—Dr. Cole's set
  - Water and mercury
- Suspensories
- Steam inhalation kettles
- Syringes
  - Leur 100 c.c., 50 c.c., 20 c.c., 10 c.c., 5 c.c., 2 c.c.
  - Insulin
  - Tuberculin
  - Intratracheal
  - Asepto
  - Irrigating, metal and glass
  - Urethral
  - Ear
- Speculum
  - Vaginal
  - Nasal
  - Ear
- Safety pins, sterile
- Trays
  - Bladder irrigation
  - Catheter, male, female
  - Perineal
  - Poultice
  - Proctoclysis
  - Rectal
  - Stupe
  - Throat irrigation
  - Vaginal examination
  - Colonic irrigation
  - Mastoid
  - Orthopedic preparation
- Tongue depressors, sterile
- Tourniquet
- Tubing
  - Drainage
  - Irrigating cans
- Tubes
  - Levine
  - Refuss
  - Rectal
  - Dakin
- Vaseline gauze
  - Granulogea
  - Vaseline, sterile jars

All dressings are obtainable in the gauze room:

Absorbent (roll)
Abdominal dressing
Applicators (long) (toothpick)
Bandages (gauze) (flannel)
Bolt gauze
Cellucotton
Cotton pads, small, large
Moist dressings
Cotton pledgets
Cleaning cloths
Gauze squares
Rolls
Bandages
Goiter pads
Mastoid, gauze
Wicks
Pads, eye
Oakum
Perineal dressings, sterile, unsterile
Prostatectomy dressings
Pneumonia jackets
Sterile towels
Stupe cloths
Stupe wringers
Sputum gauze
Thyroid dressings
Treatment sheets
Thomas splint hammocks
Tray covers

The central supply room saves in many ways:

I. *Economy of Equipment*

A tray or utensil may be used in one ward and returned to central supply room, put in condition for use, and sent to another hall for service. This may be repeated several times a day. Hence the equipment is kept working for the hospital, not left standing idle in a cupboard or some hall, while on other halls, owing to an unexpected number of treatments, the nurses are either wasting time running about borrowing equipment or ordering new material from the commissary. In a few days the demand for this surplus has subsided and the extra equipment goes on the shelf until needed again for future service.

II. *Durability of Equipment*

Gloves are tested and patched before being put in cases for sterilization. Gloves with torn wrists or with many patches are used for rectal trays and inunctions. Keeping needles in proper condition is an important problem. Our needles are soaked in a solution of lysol and distilled water. The corrosion on the inside of the needles is removed by friction of the stylet and cleaning powder, then the needles are washed carefully and sharpened on a fine oil stone. To sharpen needles properly requires experience and accuracy. The stone must be fine, hard, and well oiled. The heavy stroke is with the bevel, then the microscopic saw-like edges are smoothed off with a gentle back stroke. Drawing the needle lightly over a piece of fine absorbent cotton is a satisfactory way to test for minute roughness imperceptible to the fingers. After sharpening, the needles are flushed out with alcohol and ether, dried with the needle drier, gauged, placed in test tubes with a cap which bears gauge and length of needle. This care prolongs the

life of the needle, and thus, with the calling in of surplus needles from the halls and centralizing the supply, there has been a great saving. In comparing our last year of sectional service, that is, 1931, with 1933 (our supply room was organized in 1932) we used over 600 dozen less needles in 1933. This was a saving of $727.

With careful cleaning and autoclaving, rubber tubing lasts much longer. The 3/16-inch and ¼x1/16-inch tubing usually performs three services before being discarded. First, it is used for intravenous or hypodermoclysis, the ends being freshened several times by trimming; next, the shortened tubes are used on irrigating cans where short pieces may be joined with an observation tube. The third use is for connecting up drainage bottles. This procedure saved the institution 50 pounds, or $60, this year.

III. *Prevention of Hoarding*

Each hall is equipped with the minimum number of treatment trays of a certain standard which is required for the type and number cared for on that division. In this way no time, effort, or space is wasted on caring for a surplus, yet extra equipment may be obtained ready for instant use by sending a requisition to the supply room. Such requisitions are filled immediately, for duplicates of all treatment trays are kept in readiness in the supply room.

A system of checking supplies in and out of the department is necessary so that the hall supervisor may know what borrowed equipment is on her floor and central supply room personnel may know where supplies are, so that all equipment may be available for use whenever and wherever there is need of it. Equipment out of repair or hidden away on some shelf is not giving the hospital efficient service and also means money tied up.

IV. *Standardization of Supplies*

Equipment used for routine treatments throughout the house should be standardized (such as 19-gauge needles for adult intravenous and 21-gauge for children). In this way the commissary department has fewer odds and ends on the shelves.

Equipment used but rarely is in reach of every ward, yet but one department is responsible for keeping it in working order. A good example of this is in the use of oxygen tents. It is the duty of the central supply room nurse to see that these tents, besides being properly cleaned and in working order, have full oxygen tanks and that the electrician checks the motor every time the machines have been used.

V. *Economy of Time*

Under such an arrangement, the nurses on the wards have more time to devote to the nursing care of the patient. They are not wasting time checking over and resterilizing equipment which is used only occasionally

yet must always be ready for emergency. The ward personnel simply washes and dries the equipment used and returns it to the central supply room, where it is repaired if necessary and sterilized and made ready for immediate service.

Time is saved in assembling equipment for emergencies. For example, for the care of severely burned patients, one cupboard is stocked with:

a) Sterile linen for the bed.
b) Sterile atomizers for tannic acid spray.
c) Tannic acid powder measured in sterile bottle ready for mixing with sterile water to make the required strength solution.
d) Sterile vaseline gauze.
e) Sterile vaseline.
f) Sterile boric solution.
g) De Vilbiss spray for heavy, oily mixtures.

Thus it may be seen that the doctor's time is saved. The unexpected call for equipment is cared for in a central place. From shelves of freshly sterilized material in the central supply room, treatment trays are assembled and checked according to the list in the Procedure Book. The work of caring for equipment is done more efficiently when people skilled in these details work in a place equipped for the task at hand, i.e., suction and distilled water for cleaning intravenous tubing, acid bath for cloudy glassware, tray with all equipment for cleaning, sharpening, gauging, and tubing needles, etc.

VI. *Safety for Patient*

Solutions and equipment used for such treatments as intravenous and hypodermoclysis should be handled in the best surgical manner. Only trained and conscientious people can do this with central service.

Equipment is sterilized regularly. Once each week all unused equipment sets are sent to the central supply room and exchanged for freshly sterilized ones. Dressing solutions and surgical supplies are frequently resterilized. Each day saline is carefully prepared, dripped, and sterilized in a room which is as free of dust as possible and which is used for nothing but the preparation of solutions. All the equipment used in the preparation of saline is thoroughly rinsed with freshly distilled water. This care also applies to the Kelly flasks and tubing, distilled water being drawn through the tubing by the use of a strong water suction. Flasks and tubes are carefully wrapped and autoclaved. Ready-made solutions for intravenous administration are now used. As this glucose comes in 1000 c.c. vacoliters and many times only part is used, the central supply room saves the waste of the remaining solution by resterilizing it according to the instructions given by the company preparing it. All new tubing is care-

fully treated to remove all preservative, i.e., cut in required lengths and soaked in 5% solution of sodium carbonate. To my mind, the preparation of tubing for intravenous treatment is most important to prevent internal reactions.

PREPARATION OF NEW TUBING

1. Cut new tubing in prescribed lengths.
2. Soak in 5% sodium carbonate solution for at least 15 minutes.
3. Draw sodium solution through tubing by strong suction, then use clear water.
4. Place tubing on *firm* table and rub between wooden blocks made for that purpose. (Our carpenter smoothed blocks of wood 1½x2½x5½ inches, shaping the upper one for easy grasping.) *Note:* Care must be taken that every inch of tubing is firmly rubbed, that the friction may loosen all the preservative from the inner wall.
5. Draw clear water through tubing to remove loosened powder.
6. Cover tubing with sodium carbonate solution, ounces 1 to quarts 1. *Boil* for 5 minutes.
7. Rinse in clear water.
8. Wash thoroughly in soap and water.
9. Rinse well in clear water.
10. Rinse twice in distilled water. Use suction to draw water through tubing each time.
11. Draw air through tubing by suction. Hang on bar to dry.

VII. *Conclusions*

The central supply room saves in many ways:

1. Less equipment is needed.
2. Well cared for equipment lasts longer.
3. Hoarding equipment on halls is discouraged.
4. Equipment and set-up of treatment trays are standardized.
5. Material does duty as long as it gives efficient service.
6. A checking system eliminates loss.
7. It is a valuable teaching project for students.
8. A spirit of carefulness is created.
9. Someone is responsible for equipment that is general property, thus keeping it in order.
10. Time is saved for both doctors and nurses.
11. Time is saved when minutes may mean life.
12. It is safer for the patient, that important person in the hospital for whom our service is given that he or she may be endowed with the most precious of possessions—good health.

Health Programs for Nurses and Employees

GEORGE O'HANLON, M.D.
Medical Director, Medical Center, Jersey City, New Jersey

IF ONE MAY INTERPRET the rare occasions on which he finds reference to the subject of "Health Programs for Nurses and Employees" in the proceedings of this Association as an indication of our interest in the matter, we must concede that none of us is sufficiently health conscious as to justify the confidence the public reposes in us or the place in the field of public health they give us.

When one thinks of the reams of paper, the quarts of ink and the aeons of time daily consumed by the staffs and personnel of our 8,000 hospitals in the making of progress notes and recording the physical findings on our thousands of patients, one might properly suppose we long since would have adopted a form of health program suited to nurses and other hospital personnel, acceptable to all of us; instead, however, if we do anything at all, the majority of us are content to accept the certificate of health presented by a pupil nurse when she applies for admission to our school of nursing, or comply with the requirements of our local health boards regarding the examinations of employees engaged in the handling of food.

To those of our number who complacently sit back and say, "As related to nurses and employees, there is no health problem in my hospital," it must come as a shock to learn that 30% of the students entering (throughout) our training schools show signs of tuberculous infection, and that in those hospitals where there are no tuberculosis patients, the average rate of infection among the senior students is about 42%, whereas in hospitals that have a tuberculosis service, either as part of the general service or as a separate unit, students, at the end of their three-year period, usually show 100% infection.

From the following facts, another important observation may be gained: The average incidence of tuberculous disease among young women is about 1½%; whereas, for instance, a study of the nurses in Chicago shows that 2.2% have tuberculous disease. Heinbach found that 12% of student nurses over a period of four years developed the disease. In California, Shipman and Davis found 2.6% developed disease. At the Eppendorf Hospital incidence of tuberculous disease among nurses rose to 4.6% while Ross in Manitoba found that among 800 nurses, 6% developed tuberculosis during the four-year period. We find in our own school the percentage approximates 4½%.

This high incidence of disease is indeed alarming. Even those of you who do not admit cases of tuberculosis to your hospitals cannot feel secure,

for every general hospital admits from time to time patients whose disease is obscure; patients in their teens are sent in for observation, their symptoms indicating pneumonia, influenza, or bronchitis. After one, two, or six weeks it is found tuberculosis is present. This unseen danger, that of the undiagnosed case of tuberculosis, is a very real one to our nurses and our personnel. While tuberculosis is our most "friendly enemy" in that it is ever present and so easily acquired, there are any number of other diseases or conditions against which we must safeguard our nurses and their aids, diphtheria, typhoid, scarlet fever, smallpox, and measles being a few against which we must immunize. We have all been taught by unpleasant experiences that we must not take at their face value the 100% health certificates so willingly given by the family doctor and family dentist to applicants for admission to our schools of nursing. Were it otherwise, our infirmary beds would not be so generously occupied by pupils convalescing from tonsillitis, tonsillectomies, herniotomies, varicosities, flat feet, ingrowing nails, or impacted wisdom teeth.

During recent years we have heard much about the great advance made in the control of disease by reason of our acceptance and the very general adoption of the principles of preventive medicine. The span of life has been increased and certain diseases accepted by preceding generations as necessary have now completely disappeared.

Awakening to a conscious realization of our responsibility in the matter of health in relation to our nursing staff and hospital personnel, we at the Jersey City Medical Center adopted in 1926 a Health Program for Nurses, which I will briefly outline. It is simple and readily fits into the daily routine.

1. Its purpose is to reduce the amount of time lost from duty by the student nurse by reason of disabling personal illness and to place the bodily functions of each student nurse in the best possible condition, so that she in turn, as a teacher of health, may be able to instruct those with whom she comes in contact how they may enjoy the blessing of good health.

The Student Health Program is administered by a council of five members. The medical director and the director of the school of nursing give personal attention to the planning of the medical and nursing policies of the program. The health consultant, a physician, as the representative of the director, has sole responsibility for all medical procedures of the council.

The health supervisor is a nurse with rank of a supervisor in the school and has sole responsibility for all nursing procedures and the execution of all medical procedures as the representative of the director of the school of nursing.

The health director, a non-professional man with broad theoretical and practical experience in health work and in college teaching, plans and directs the health program. The council meets regularly at stated dates and never functions unless there are three present.

2. *Time.*

Most of the program is carried out during the preliminary period. When the class enters, there is a period of orientation from three to five days during which the health director gives a health lecture, the purpose of which is to acquaint the class with the program and endeavor to make them health conscious, incidentally enlisting their full coöperation for the tests, examinations, etc.

3. A physical audit is then made—each student is given a complete physical examination by the specialist of each department, the specialist in each instance being the director or chief attending physician on the respective service.

1. Dermatologist.
2. Orthopedist—Shoes prescribed—corrective exercises given.
3. Cardiologist.
4. Phthisiologist—Particular attention given these.
5. Otolaryngologist.
6. Ophthalmologist.
7. Dentist.
8. Neurologist.
9. Gynecologist—Only when especially indicated.
10. Surgeon.

4. Each of these examiners makes a detailed report of every deviation from normal bodily structure and function found by him in his department of medicine.

These findings are recorded on individual charts, these being used as permanent records and guides for future health work in connection with each individual student.

5. After the completion of this first physical audit, each student has explained to her in non-technical language the findings and exactly what is expected of her in the correction of these defects before the completion of the preliminary period. The entire resources of the hospital's physical plant and trained personnel are placed at the disposal of each student for the carrying out of the instructions. Prior to graduation, after another physical audit, similar health counsel is given to each student with a view to having her leave the hospital in as nearly perfect health as medical science at the present day can accomplish. After each convalescence, which necessitated hospitalization, each student is given the same painstaking health counsel with a view to discovering and preventing a recurrence of

the condition which led to the illness from which she has just recovered.

In addition to the development of health consciousness by the physical audit and by health counsel, the program attempts to protect the student nurse against communicable disease by the immunization program. Each student nurse is given absolute protection against smallpox by vaccination, according to the Leake method. Each student nurse who is found Schick-positive is given absolute protection by inoculation against diphtheria until she shows by test that she is Schick-negative or no longer susceptible to diphtheria. Each student is inoculated against typhoid fever and reinoculated whenever a Widal shows she is again susceptible to typhoid. In addition to these three inoculations, each student nurse is also given a Dick test to determine her susceptibility to scarlet fever; a Wassermann test for syphilis; a Mantoux to discover if she has at any time been affected by tuberculosis; a Tallqvist test of her hemoglobin; a urinalysis; and in cases where indicated, a basal metabolism.

Classroom Instruction

Nor is the school instruction in personal hygiene good (as it is for the purof the examining room and of the counsel room are not deemed adequate. Nor is the school instruction in personal hygiene good (as it is for the purpose for which it is given deemed adequate) since the correlation between the personal hygiene of the curriculum and every-day life is not always perfect. To supply this deficiency, the health director gives to the students during the preliminary period informal round table presentations, a series of non-technical discussions on immunization, orthopedics, hygiene of heart and lungs, colds, and the hygiene of the gastrointestinal tract, including teeth and weight control. The students are encouraged to discuss their individual health programs with the health director, at health counsel, and also at these informal round table meetings.

Field Trips

To give to the students an adequate conception of the social aspects of health consciousness, as well as the individual aspects, they are given a series of field trips, under proper supervision, to community activities which seek to develop and protect individual health. The most instructive and valuable of these field trips is undoubtedly the one to the largest plant for the commercial production of certified milk in the state of New Jersey. Here each student is enabled to see how the best grade of milk is being produced at the present day. Other trips take the student nurse to—

Water chlorination plant.
Sewage disposal plant.
Packing house.
Beverage plant.

Control

The health council seeks to control the health program in several ways. From the student's point of view, the most important control is the student's individual weight chart. Each student is required to keep a weight chart, a prescribed form with weekly or monthly entries, as directed, and to present this chart for inspection whenever called upon. It has been found that the weight chart is frequently a valuable indication of impending deviations from normal health. The health supervisor submits to the health council a monthly record of each case of student disability necessitating hospitalization, with the diagnosis, the period of hospitalization, and the name of the attending physician. The monthly health index is computed for each class and for the entire school for purposes of statistical control. This index is computed by subtracting from unity the quotient found by dividing the sum of the days lost through illness by the members of the group, by the product of the number of students in the group, multiplied by the number of days in the month. Each student is given an individual health rating after her health audit at the commencement of her preliminary period, and as she corrects each deviation from normal bodily function and structure noted on her health audit her individual health rating is raised until she has attained the maximum rating.

The school dietitian provides for each underweight student a special building diet and for each overweight student a special reducing diet. The cardiologist of the hospital, who is a specialist in reducing, gives personal advice and prescription to each overweight student. There is special nourishment for the underweight student in the middle of the forenoon of each day. Refreshments adapted to the physical need of each individual student are furnished to the student at each of the informal round table health talks in the school library.

A physical director with professional training in her specialized field supervises the corrective and recreational work of the student nurses in the school's gymnasium.

Rewards

As rapidly as each student, during her preliminary period, succeeds in removing all remediable deviations from physical normality, she receives a certificate attesting that fact. On Commencement Day each graduate who is free from any remediable deviations from physical normality receives at the same time she receives her diploma a health certificate attesting that fact. For the member of the graduating class whose health record throughout her course is the best in her class, provision has been made for a health award having an intrinsic value of $50.

Forms

The printed forms used by the school in connection with the health record consist of a physical audit folder (which is at present being revised) containing the detailed findings of the student's physical audit and her health rating. In this folder, all of the other health records of the student may conveniently be filed. The personal history card gives a detailed account of the health record of each student prior to her admission to the school.

The Leake test sheet records detailed information regarding each of the 14 days of the smallpox vaccination period.

The urinalysis report tag gives the usual detailed information regarding this procedure.

The weight card presents for ready reference a graph of the student's weight prepared at weekly or monthly intervals.

Conclusion

Your reaction to this hastily sketched outline of a health program may be that it requires too much time, that it does not entirely eliminate illness from the nurses and consequently is not justified, considering its possible inconvenience.

From the student's personal point of view, it is justified because it places the girl's bodily machinery in the best possible condition to meet the demands of her professional duties and the health dangers of her professional life.

From the school's selfish point of view, it is justified as a serious attempt to reduce the amount of time lost by student nurses because of personal illness, with the resulting additional burden which such personal illness casts upon the student's classmates.

From a pedagogical point of view it is justified because no method of teaching is as effective as the personal practice of the principles taught.

From the social point of view, it is justified because it gives the best possible equipment by personal example to those who are being prepared to become health teachers to the nation.

From an economic point of view, it is justified as a contribution to the reduction of the enormous annual loss from preventable personal illness.

From a professional point of view, it is justified because it gives an intimate personal touch to items in the school curriculum and in hospital technique.

Additional personnel for its operation is not required. Every part of the program is so scheduled that it fits into the daily routine without conflict or confusion. Like all programs, to be successful you must first believe

in it yourself. In addition to the physical audit or general health examination, which I assume we are all giving new employees, a similar program with modifications suitable to the departmental needs may be made applicable to all groups of hospital employees.

Sales Taxes and Hospitals

Local sales taxes, state and municipal, are becoming increasingly numerous. Hospitals in New York City, so Dr. Goldwater advises, felt that they should be exempt from the operation of the tax and immediately instituted their request for exemption, and, as indicated by the following correspondence, will secure such exemption.

New York's example in this matter may be a stimulus toward suitable action on the part of hospitals in other cities and states.

December 10, 1934

Hon. F. H. LaGuardia
Mayor, City of New York
City Hall, New York

My dear Mayor LaGuardia:

At the Academy the other night you asked me to suggest a definition of hospitals doing charitable work, which should be exempted from the operation of the Sales Tax. Exemption should, in my opinion, be granted to—

"Hospitals which are supported in whole or in part by public subscription or endowment, are not operated for profit, and are incorporated by special act ot the legislature or under the provisions of the membership corporations law with the approval of the State Department of Social Welfare."

For comparison, I quote the administrative order issued in Washington, granting exemption from the provisions of the NRA code:

"Semi-public or voluntary hospitals are those which are supported by public subscription or endowment and not operated for profit."

Sincerely yours,

S. S. Goldwater, M.D.
Commissioner

SSG.CG

City of New York
Board of Aldermen
City Hall
Office of the President

December 11, 1934

Dear Commissioner Goldwater:

Your letter to the Mayor of December 10th, 1934, in relation to the definition of hospitals doing charitable work for proposed exemptions from the operations of the sales tax, has been referred to me. I advise you that the matter has been considered and the necessary exemption will be contained in the amended bill.

Sincerely yours,

Bernard S. Deutsch
President, Board of Aldermen

Dr. S. S. Goldwater
Commissioner of Hospitals
Municipal Building
New York City

The Romance of a Hospital*

BORIS FINGERHOOD
Superintendent, Israel Zion Hospital, Brooklyn

GENERALLY, the layman comes in contact with hospitals on only two major occasions—when he or a member of his family is sick and when the hospital comes to him for contributions. When he comes to the hospital for relief—either in general illness or in an emergency—he very frequently gains the wrong impression, for he is excited, alarmed, or distressed and cannot understand the matter-of-fact way in which his arrival is treated. Those who escort the patient to the hospital take it for granted—erroneously, of course—that everyone in the administrative machinery of the hospital who fails to show distress is unfeeling, unsympathetic, and hardened to everything about him. At first flush, these friends or relatives expect everyone with whom they come in contact to get into the same alarmed frame of mind in which they unfortunately find themselves. Little does the public realize how deeply stirred hospital employees may become—without in any manner showing it—at the sight of real injury or severe illness. That they conduct themselves in an unemotional manner simply shows that they are trained to keep cool and outwardly calm in the face of most heart-rending situations, for in that coolness and calmness often lies the solution to many a problem.

I am reluctant to abuse the hospitality of this station by attempting to recite instances, horrifying and hair-raising, to illustrate the point that I am trying to make, so I shall not dwell on this phase of hospital contact any longer.

The other occasion when the hospital and the layman meet, an occasion with which I hope many of you are familiar, is the time when appeals for funds are made. The extent to which your heart strings are pulled and your purse strings opened depends largely upon the tactics and ability of the people engaged in the publicity of the campaign for their particular hospital. The charity work that is stressed, the recoveries that are reported, the saving of lives that is described—all are enumerated in more or less understandable tables of statistics and presented to the public. At practically no other time does the layman see or hear of how the hospital in his neighborhood functions, or to what extent the hospitals carry on the work entrusted to them.

Today, we shall not turn our attention to those phases of our activities. We are primarily concerned with the drama that is part of the inner work-

*Radio address delivered at Philadelphia

ings of a hospital—the conflicts and the struggles, the rivalries and the deep-rooted relationships, the hopes and disappointments, the striving for progress and accomplishment that exist in the heart of a hospital. No other field of endeavor may compare with the hospital in this respect. Let us, for instance, see if the character of the average hospital resembles in any way that of any business establishment.

It might seem on the face of it that in many respects a hospital is founded upon and functions along the same lines as does any business enterprise. A hospital, it appears, has for its commodity service to the sick. For this it charges definite rates to various classes of people and differs from a business only in that it gives its commodity *free* to those who are unable to pay for it. Otherwise, it may be believed, a hospital has for its incentive the same motives that underlie any business institution. It is my hope that I may succeed, in the limited time at my disposal this afternoon, to dispel this erroneous belief and to show how wide the difference is between the two endeavors and how unalike are their motives.

A business, even one which is engaged in the sale of some kind of service, has for its motive and incentive only one thing—profits. Whether it is a life insurance company, a financial syndicate, or any kind of commercial undertaking—its aims are purely and unalloyedly profits and larger sales and again profits. Such establishments are constantly striving to enhance their usefulness with one view in mind—larger sales and more profits. All their efforts for improvement, all their attempts for betterment of their product are directed toward one thing—better and bigger sales, more and larger profits. This you will find in every commercial endeavor. Not so in the hospital where the public is interested not through private ownership, but through trustees who direct the policies of the institution.

Be it a hospital in some rural district, with a bed capacity of 25, or a large institution in some big metropolis with beds for five or six hundred sick, its only incentive, its only motive, its only ultimate goal is the finest and most perfect service, irrespective of cost or effort. Whether it is in the purely administrative phases, or in the nursing or medical care of the institution, from the humblest to the most highly recognized worker, everyone associated with the work of a hospital has one and one aim only—the best, the surest, the safest way of helping those who are in need of its services. No business institution may truthfully point to any such motivation, no establishment dealing in any kind of commodity may point to any such goal, and in that lies the great claim that hospitals have for widespread support from the public. In that lies the great romantic appeal

that hospitals have for the public and the communities in which they function.

Another phase of hospital work which is little known to the public and whose romantic side has never been adequately portrayed is the research work in which most hospitals are engaged. The research laboratories of hospitals are constantly laboring to find ways not only of curing illness but of *preventing* it. No commercial research, no industrial research, has for its goal the elimination of the product of the concern for which it is laboring. Its only aim is a larger output and a smaller cost, whereas the goal of hospital research is the prevention of illness and healing of the sick, not from the angle of less cost or less effort, but from the point of accomplishing the most good at whatever cost necessary to bring about the desired results! Every research department of a hospital is motivated by one aim only—the finding of sure and safe preventives and speedy and safe cures—and labors for the *eventual extermination of the need for any service in which the hospital is engaged.* To conquer the forces that constantly play against life, to control the ravages of illness that hold us in their grip, to create a wall between illness and health, is indeed to experience a thrill that comes with the dramatic and romantic moments in life. Toward this ultimate aim the hospital research department labors and in recent years has made some hopeful progress.

There is romance in statistics, too. When monthly and yearly reports by hospital departments show a marked decrease in mortality, and an increase of recoveries in various diseases, there is a thrill that cannot be measured with any sort of detecting-instrument. When a year goes by without an infantile paralysis epidemic or some other disease that is almost its equivalent in the disaster it brings, another ode to joy is sung in the hearts of those who are associated with hospitals. Or when a new serum or remedy that counteracts disease is found and works wonders within the hospital wards, new hopes are born, new worlds seem conquered.

But there are bitter moments, too, in the drama that statistics enact for us. When in depression years, free cases come in more often, when public ambulances are constantly summoned, when the dispensaries are crowded to overflowing—then we know that the world outside is sick (at heart), that the tragedy of life has become greater than ever, that the Demon of Despair and Disappointment is visiting where heretofore it had hastened swiftly by.

There are other phases of hospital work not discernible to the public's naked eye. In them the pulse of the hospital heart beats rhythmically. Of them, the most vital is the spirit of coöperation that exists among hos-

pitals. It is a healthy sign, as is evidenced by the fine work that is done in the local and national associations to which the hospitals belong.

While hospitals are to some extent similar to commercial and industrial undertakings in their keen rivalry among themselves—each hospital striving to improve upon the work of its fellow hospitals—yet unlike the commercial enterprises, no unhealthy attitude of competition and antagonism exists, for those of us in hospital work believe that in coöperation and not in competition lies the mainspring of human endeavor. We do not keep the secrets of our particular accomplishments to ourselves, but try through the aid of our local and national associations or through exchange visits to impart to one another all the possible information we may have gained as a result of our painstaking efforts.

It is at such meetings and conventions as the one going on at present in this city—I refer to the American Hospital Association Convention in Philadelphia this week—that the best hospital work is carried on. Here all hospital heads are assembled to discuss in open meeting the problems that confront them at home. Here at round table discussions views are exchanged, old theories exploded, and new theories formulated. Here the work of young hospitals is encouraged and that of the old and experienced institutions emulated. Here, as in other meetings of hospital associations, ideas and knowledge are shared so as to enable these houses of healing to go farther in their good work, to make greater progress on the road to prevention and cure of disease. Therein and in those other quietly-functioning forces of hospital life heretofore discussed lies the Romance of a Hospital.

The Walter Burns Saunders Memorial Award

WORD HAS BEEN RECEIVED by the American Nurses' Association from Mr. W. L. Saunders of Philadelphia that recommendations for the Walter Burns Saunders Memorial Medal may be made by persons other than nurses. Heretofore candidates for this award have been recommended only by members of the nursing profession.

A Trial of the Eight-Hour Day for Hospital Special Nurses

SALLY JOHNSON
Massachusetts General Hospital, Boston

DURING THE CURRENT YEAR much has been written and more has been said about the eight-hour day for hospital special nurses. On one phase of the subject there has been general agreement: namely, that from the standpoint of the nurses, an eight-hour day is right. The reasons for this general agreement do not need to be presented.

But wherever the subject is discussed, the question is almost immediately asked, Is an eight-hour day right from the standpoint of the hospital, of the doctor, and of the patient? That data relative to the answer of the question may be presented before this audience, I was asked to review the six months' trial of eight-hour nursing which the Massachusetts General Hospital and the Massachusetts Eye and Ear Infirmary are conducting. The review covers five months of the six—May through September.

The review of a trial in one institution only, and for a period of five months only, might at first seem too limited to be helpful. But when one realizes that during these months the daily average number of patients was 731 and that the Central Registry filled 3,778 calls from this institution for special nurses, the trial appears more extensive.

It is well to explain that the Massachusetts General Hospital and Massachusetts Eye and Ear Infirmary are two separate institutions, but as they have a hospital director and a superintendent of nurses in common, and as there are other common administrative factors, the institutions in this review are referred to as one. In the Massachusetts General Hospital there are three main divisions for the care of bed patients: the general hospital for ward patients, the Baker Memorial for persons of moderate means, and the Phillips House which is the private pavilion for persons of considerable means. It will be seen that the unit cares for patients of the three economic levels, and that it also cares for a group of special patients at the Infirmary.

Therefore, the members of the administration, medical, and nursing staffs are of the opinion that they have had a sampling at least of most of the problems that present themselves when the eight-hour plan for hospital specials is in effect.

As the number of hospitals where the eight-hour plan is in effect is growing, it is probable that many administrators will be asked to give consideration to a similar plan in the hospitals where they are affiliated. When the subject comes up for consideration, certain questions will at once

present themselves and you will wish to know how other institutions solve them. Ask them. Profit by the experience of others. Then discuss the new policy with representatives from all the groups within your own institution which would be affected by such a change. No procedure could be more fatal than to precipitate such a change upon an institution before the new plan had been carefully interpreted, considered, and discussed.

The general movement toward this eight-hour day probably had its inception in the nation-wide movement for shorter hours, that work might be shared. Further impetus came from the demands made upon the hospitals to lessen the production and increase the consumption of graduate nurses.

Locally, in Boston, the first step was made by the private duty section of the Massachusetts State Nurses' Association. A committee from that group studied eight-hour plans already in operation, their nearest source of information being the Newton Hospital where a plan had been in operation for several months. After this study, the committee made contacts with presidents of the alumnae associations and then with the principals of the schools of nursing. The latter presented the subject to the hospital directors and to the Training School Committees. The hospital directors in turn presented the subject to the executive committees of the medical staffs and the hospital trustees. In a few instances members of these groups discussed the subject with former and with potential patients. Each group also sought information from like groups: trustees conferred with other trustees, physicians with other physicians, and principals of schools of nursing consulted principals of the schools where the plan was already in operation. The discussion did not stop within the group, or even within like groups, but extended into conferences among the various groups. One of the most helpful conferences included representatives from the private duty section, a superintendent of nurses of long experience, and a committee of the Medical Superintendents' Club.

The time came when these persons and the groups they represented were of the opinion that an eight-hour day for hospital specials was right. Therefore, a number of Boston hospitals, in the spring of this year, voted to give the eight-hour day a six months' trial with the provision that the maximum total cost to the patient for 24 hours for three nurses should not exceed $15. This sum was exactly the same as the cost to the patient for the two 12-hour nurses before the salary and board cuts of 1932 reduced the cost to the patient to $12.

The plan in the different hospitals varied somewhat as to detail. In this institution the morning period of service is from seven to three, the evening from three until eleven, and the night from eleven in the evening

until seven in the morning. Each nurse is paid $4.50 for an eight-hour day and in addition is provided with two meals for which the patient pays the hospital 25 cents per meal. To the patient, therefore, for each nurse for each eight hours the cost is $5, or a total of $15 for three nurses covering the 24-hour period. Occasionally there is need for other periods of service, as for that patient who may need a special nurse to come on duty in the middle of the morning or in the early afternoon. For this need the following is the plan: A nurse who is on duty more than four hours is paid $4.50 and goes off duty at the end of that period. A nurse who is on duty fewer than four hours is paid $2.25 and may continue on duty the following period of eight hours. For these two periods, a total of 10 to 12 hours, she is paid $6.75 and the hospital is paid 75 cents for three meals.

Besides the important matter of cost to the patient the preliminary discussion included possible effects of the new plan upon the physician, upon the hospital, and upon the personnel. Time showed that the effect upon the hospital and its personnel was the least carefully considered, and so there were occasional surprises: for example, about two days before the plan was to go into effect someone realized that the nurses coming in from outside would no longer be changing from street clothes to uniform and vice versa at seven in the evening, but at three and eleven. Since many of the nurses use dressing booths in the out-patient department, which closes at five, there was consternation. But when the number of nurses using the booths was checked, it was found that the majority lived near enough to come to the hospital in uniform. Therefore, a small number of booths was built near the central clothes room and that difficulty was solved.

Another day someone realized that there would be two groups of nurses to be provided with the night meal where formerly there had been only one. This seemed a real problem, but an actual count showed that there was no increase from May through August. An increase came in September, but even then the average daily increase was only eight. Many evening nurses did not care to go to the late evening meal.

For several of the hospital personnel the eight-hour day for hospital specials has definitely increased the work—for the house officer, who must decide for which period of service the patient's need is greatest, for the clerk in the bookkeeping office who posts the charges, issues the bills, and writes the checks, and, most of all, for the nurse executive who calls, registers, and assigns the increased number of special nurses.

During the preliminary discussions one of the questions which the hospital executives considered of importance was the cost to the hospital. First, as to meals: can the hospital afford to provide meals at the rate of

25 cents? Second, will it be necessary to provide additional floor duty nurses if the number of specials were reduced? The figures relative to the cost of meals seem to indicate there has been no actual loss. There is no evidence of the need of adding to the floor duty personnel. A longer experience or an increased daily census of patients may alter both of these answers.

One hospital superintendent of long experience said in substance: "The new plan may increase hospital costs to some degree, but there is considerable question as to whether the hospital should continue a situation wherein any group of its workers is on duty 12 hours." Another said: "In view of the fact that the nurses have reduced their fees to a very large degree, is it not right that the hospital should expect a reduction of income from the board of nurses?" And a superintendent of nurses said: "It should be remembered that if special nurses were not employed by the patient, it would be necessary for the hospital to employ a larger number of nurses in order that these patients might be given adequate care. Therefore, should the hospital sustain some loss on the board of nurses, there is no reason for great concern."

On October first, five months of the six months' trial had been completed. At that time a study was made in an effort to determine the extent to which the eight-hour day actually had affected the cost of nursing to the average patient, the spread of employment among nurses, and the earnings of nurses. There was also an attempt made to compare the number of night nurses employed under the new plan with the number employed under the old. The work of all this comparison has been a time-consuming and often an exasperating task. Many persons shared it. Had the necessary data been recorded in 1933 the comparisons would have been relatively easy, but such data were not kept. Therefore, a large number of 1933 day books, charge accounts, and lists of patients and nurses were surveyed, checked, and rechecked before a comparison could be attempted. Only a few of the nurses had memoranda of the earnings of 1933. Therefore, the earnings of only a small number of nurses, as presented by them, have been compared.

It is to the ward patient who is specialled that the eight-hour day has apparently brought the greatest increase of cost. This is because he has a special only when there is dire need, and if he needs a special at all, he probably needs one for the entire 24 hours. It so happens that this year the cost for the special care of patients who have been in special apparatus for some time affects this comparative cost. However, the comparison of the figures as they stand appears to show that the amount paid for special nursing of the ward patient on the eight-hour plan is $16.05 or 23% more per patient per month.

In the Baker Memorial the nursing care furnished by the hospital is liberal. There is a large number of floor duty nurses. Specials are used only when there is real need. They may be omitted earlier than at the general hospital because there is a more adequate floor staff on duty at night as well as by day. The figures for that department indicate that the cost to the average patient per month was $1.08 or 01.2% *less.*

In the Phillips House, the private pavilion, where the patients are financially able to meet the cost of such specialling as they desire, the figure indicated that on the eight-hour plan the average patient paid $8.50 or 7% more per month for special nursing.

In the private floor of the Massachusetts Eye and Ear Infirmary the number of days of special nursing is usually low as the patient's stay is relatively short. But during the few days following operation special care, if needed at all, is often needed for the entire 24 hours. Therefore, while the increased cost in dollars is about the same as at the Phillips House, it is higher in per cent for the Infirmary. The increased cost per month appears to be $7.78 or 19% per patient.

It has been claimed that savings to the patient may be accomplished through the fact that under eight-hour nursing the night nurse may be dropped sooner than under 12-hour nursing. Our brief experience confirms this, though the figures are not startling. Under 12-hour nursing there were 72% as many night nurses employed as day nurses, while under the eight-hour plan the number of night nurses employed was 63%.

And now about the increase and spread of employment among nurses. Data on this subject are difficult to obtain because of reasons already explained. However, the following statements are sufficiently accurate to be worthy of record. The number of nurses on the waiting list at the Central Registry through which the nurses are called has been lowered in per cent from 50 to 75.

In the Baker Memorial during the five months of May through September, 1934, there were 98 more individual nurses employed on the eight-hour plan than during the comparative months of 1933 on the 12-hour plan. This was an increase of 70%.

In the Phillips House the spread of employment increased by 43 nurses —23%. In the Massachusetts General Hospital the increase was 71 nurses—58%. This represents an average daily increase in the entire Massachusetts General Hospital of 58 nurses employed. In considering this comparison it must be remembered that the daily average census of these three departments increased by 34 patients.

There has been some question as to whether it would be wise to include in this survey any statement relative to comparative number of days

employed and comparative earnings of the nurses. Not only do nurses themselves lack accurate figures upon which to base comparison, but many say that they took vacations in the summer of 1934 which they could not afford to take in the summer of 1933. All these factors must be kept in mind when the statement is made that the records submitted by the nurses appear to show that the average monthly increase of employment was five and a half days. The figures also seem to show that the average monthly increase in earnings was $13.05. But in considering this increase, or in any other increase reported where figures may be more valid, it must be remembered that from any increased earnings the nurse must pay for one meal a day that was formerly furnished to her.

October first was also the date when questionnaires that had been circulated among nurses, physicians, and patients were collected and surveyed. About 125 nurses were asked whether they wished the 8-hour day to continue. The "yes" was unanimous. The reasons for this affirmative answer were variously expressed, but included the following points: "On the old plan my life was divided into two periods,—one on call in my room waiting long dreary days, and the other at work, long hours, when I could do little else but work and sleep. On the new plan the waiting periods are much shorter and the working day much shorter. Now I find time for the normal interests and activities of life. I am happier both on duty and off duty. I am sure that I am more of a person both on duty and off duty. I am equally sure that I am a better nurse."

One hundred physicians on the medical staff answered the questionnaires. Six wished to reserve an expression of opinion because of lack of experience with the new plan. Thirteen were of the opinion that the plan was not acceptable. Their chief reasons were: increased cost to patients, difficulty which the patients might find in making the adjustment to three personalities, difficulty in securing three nurses expert in certain nursing techniques, and the fact that the visiting physician seldom sees the nurse on night duty. There were six physicians who, with minor reservations, were favorable. The number who were entirely favorable, although fully cognizant of the factors to be adjusted, was 75. Several of this group made their affirmative replies more emphatic by adding such statements as the following: "The shorter hours are more just to nurses and patients alike." "The cost may often be lessened by omitting one nurse." "The nurse should be considered and I believe that when doctors and patients become accustomed to the change they will like eight-hour nursing." "The plan should have come 15 years ago." "If the case is difficult, eight hours are long enough; if there is little to do and the nurse is a so-called 'luxury' nurse, eight hours are long enough for her to endure the tedium."

The question, "Do you approve of the eight-hour plan for hospital special nurses?" was asked of 250 patients. Of these, 26, or 10%, stated that they did not approve. Everyone will sympathize with the negative reply of the patient whose eyes were bandaged for several days and, therefore, at first found the adjustment to three nurses difficult. The other reasons for the negative answers were increased cost and necessary adjustment to a larger number of personalities. However, nearly everyone of the 26 patients stated that 12 hours was a long time for a nurse to be on duty. Twelve patients felt that they lacked experience with 12-hour nursing and, therefore, had no basis for comparison. Of the total 250 patients approached, 212, or 84%, approved without reservation. There were two major reasons for their approval: one, eight hours is a long enough period for anyone to work and no other worker is expected to work a 12-hour day, and, two, the eight-hour plan provides a happier and more efficient nurse.

Before drawing any conclusions from this study, we must bear in mind, first, that the survey itself is too limited to warrant the acceptance, without challenge, of the figures reported; second, that the 1933 data on the subject are not as reliable as those of 1934. But the survey is an earnest, perhaps courageous, attempt to interpret intelligently and accurately the mass of figures that is available.

Further study will be stimulated when someone challenges the statement that the eight-hour plan for hospital special nurses has increased the cost of specialling to the average patient per month $16.05 in the general hospital, $8.50 in the Phillips House, $7.78 on the private pavilion of the Massachusetts Eye and Ear Infirmary, and decreased the cost $1.08 in the Baker Memorial.

Another statement which is repeated for emphasis can withstand a challenge. This statement is that in reply to questionnaires, 100% of the 125 nurses who responded are in favor of the eight-hour day. Eighty-one per cent of the 100 physicians who responded registered themselves as being favorable. Only six of these made any reservation. Eighty-four per cent of the 250 patients questioned recorded themselves as being favorable without reservations.

Again we urge you to remember that above all else it is of paramount importance that the director of any institution where a similar experiment is contemplated endeavor to have all who share in the experiment inform themselves upon the subject. An equally important step is an intelligent and sympathetic discussion among representatives from all groups who participate in the experiment. The preliminary discussion and gathering of information has been to a great extent responsible for the high degree

of willing coöperation which has prevailed among the many participating groups in this institution.

In closing, the speaker begs the privilege of saying that she has had 18 years of experience in interviewing prospective applicants to schools of nursing. Based on that experience she is of the opinion that an eight-hour day for hospital special nurses will do much to reduce parents' objections to nursing as a vocation for their daughters. The removal of this parental objection will bring into the school a larger number of young women who possess integrity of character, an acceptable social background, the attributes of a desirable personality, and a higher level of education. Any plan which will tend to accomplish this result is worthy of serious consideration, for it will improve nursing from the standpoint of the hospital, of the nurse, of the physician, and of the patient.

Coming Meetings

New England Hospital Association, Boston, February 7-9.

Council on Medical Education and Hospitals of American Medical Association, Chicago, February 18-19.

Western Hospital Association, San Francisco, February 18-21.

Texas Hospital Association, Marlin, March 22-23.

Ohio Hospital Association, Columbus, April 2-4.

Iowa Hospital Association, Iowa City, April 29-30.

Illinois, Indiana, and Wisconsin Hospital Association, Chicago, May 1-3.

Hospital Association of Pennsylvania, Philadelphia, May 8-10.

Michigan Hospital Association, Jackson, May 9-10.

Mississippi Hospital Association, Biloxi, May 13.

Connecticut Hospital Association, Willimantic, June.

Hospital Association of Nova Scotia and Prince Edward Island, Wolfville, N. S., June.

Minnesota Hospital Association, Duluth, June 20-21.

American Protestant Hospital Association, St. Louis, September 27-30.

American Hospital Association, St. Louis, September 30-October 4.

National Association of Nurse Anesthetists, St. Louis, September 30-October 4.

American College of Hospital Administrators, St. Louis, September 30-October 4.

American Occupational Therapy Association, St. Louis, September 30-October 4.

American Association of Hospital Social Workers, St. Louis, September 30-October 4.

Children's Hospital Association, St. Louis, September 30-October 4.

American College of Surgeons, San Francisco, October 21-25.

The Organization of an Anesthesia Service

HOWARD BRADSHAW, M.D.
Boston, Massachusetts

THE DAY OF "POURING" ETHER has passed forever, we hope. We are no longer content with rendering a patient unconscious in order that the surgeon may proceed. Pharmacologists and physiologists have emphasized for years that drugs capable of producing unconsciousness are powerful drugs and capable of producing other marked physiological reactions. We, as clinicians and hospital executives, have apparently ignored these facts until comparatively recently. This is evidenced by the lack of organized departments of anesthesia at the present time. In fact there are only a few such departments worthy of the name throughout the whole country.

Some valuable anesthetics have fallen into disuse or at least into relative disuse because they have been improperly used. Ether is an outstanding example of this. Many of the accidents occurring during an operation are often charged to the drug used. As a result of such a feeling, often a more dangerous drug is substituted for ether. Explosions occurring during the administration of certain of the gaseous anesthetics would be better related to the apparatus or the anesthetists rather than the drug per se. Definite and sure means are available for the prevention of such accidents.

At the present time, the majority of anesthetics are administered by nurse technicians, general practitioners, or practitioners who have gone into anesthesia as a specialty without preliminary training, or by the youngest and most inexperienced of the house officers. There is no place in medicine where therapy is carried to such an extreme as in anesthesia. Every patient that is carried into deep anesthesia is certainly carried to a point closely approaching death.

Surgery has made rapid progress especially within the last few years. There are actually hundreds of surgeons in this country who are capable of performing the usual operation adequately. Many surgical procedures have become standardized so that there is little doubt about what should be done in a given situation. Unfortunately, no such condition exists in the anesthetic field. A great deal of this is, no doubt, due to the relatively little attention that has been given to it.

An analogy between the development of an anesthesia service might well be drawn. In x-ray there was, at first, a technician or nurse technician under the most casual supervision, usually a surgeon. Many of the small hospitals have been forced to keep this up, although some have a visiting radiological service for interpretation of films and supervision of

technicians. This is, of course, the situation that prevails at the present time in most hospitals regarding their anesthesia service. Those interested in the organization of a department of anesthesia might well follow generally along the lines that radiologists have in the development of their specialty as an organization.

Since the fall of 1933 some steps have been taken in the direction of getting an organized department of anesthesia at the Massachusetts General Hospital, and I shall attempt to present some of our views on such an organization.

At the outset, we should like to state that we do not care to enter into the prevalent discussion of medically trained specialists versus nurse technicians in anesthesia. There are many obvious reasons why such a discussion is futile at the present time. Until medical schools include adequate instruction in anesthesia in their curricula, and until hospitals give a service in anesthesia to their house officers, there can be very few medically trained specialists in anesthesia. The giving of an occasional anesthetic is not enough. There are many small hospitals that would have difficulty in attracting and recompensing a trained medical specialist in anesthesia, so that we feel a sudden and radical change in the present system is not justifiable, at this time, at any rate.

We believe that a department of anesthesia should be under the direct supervision of a graduate in medicine. This individual should have been trained more in the surgical than in the medical field, because it is well to know just what a given surgical procedure demands from the anesthesia. He should also be trained in the physiology of respiration, and of gas exchange in general, and be familiar with the pharmacology of pain-relieving and sleep-producing drugs. He should also be teacher, organizer, and investigator. In addition to him, there should be graduates in medicine who are classed as house officers in anesthesia for one year, at the end of which time if they are suitable, they become residents in anesthesia for one year. The resident should be in direct charge in the operation room, assigning cases and advising in unusual cases and emergencies. Some of the residents would be promoted to assistant and others would be sent on to other hospitals in need of their services, the object being to have the work personally supervised by medically trained individuals, and to have a certain number of physicians in training at all times. The remainder of the personnel should consist of graduate nurses who are getting or have had their training in the department.

It should be the function of every hospital of any size to serve as a place of training and an educational center for smaller and more remotely removed hospitals. Therefore, we feel it is our duty to train nurse tech-

nicians so that they can assume charge and intelligently supervise departments in smaller hospitals.

Some member of the anesthesia department should see all cases before operation and prescribe the medication incident to the anesthetic. He should also be allowed to prescribe the anesthetic to be used in a given case. The advantages of this are obvious and need not be elaborated. Of course, one might argue that this assumes some of the surgeon's prerogative, but all thoughtful surgeons welcome any aid that can be given them. With so many new agents and techniques being introduced almost daily in anesthesia, it is the rare surgeon who keeps abreast of them.

The department should follow all cases postoperatively in order to profit by its errors. All postoperative complications should be discussed in regular scheduled meetings of its members.

From the foregoing, it can be seen that we believe a department of anesthesia should function as a distinct unit in the hospital, just as a medical or a surgical service functions. To do this, it must be composed of individuals properly trained in the specialty, and must not be relegated to an insignificant and often neglected place in such a large and diverse department as surgery, as is common at the present time.

Hospitals Victimized

SOME TWO MONTHS ago a respectable looking man, 5 feet 11 inches tall, red complexion, about 180 pounds in weight, presented himself for admission to the Presbyterian Hospital. He asked for a ward bed and, evidently knowing the rules of hospitals to collect a week in advance, presented a check for $50 more than the week's charge, bearing the forged signature of an official of a coal company. He received the $50 in cash.

He was taken to the ward by an orderly and stated he would go out and collect his luggage and would return.

The check, when presented for payment, was pronounced a forgery and the hospital was victimized of the amount paid the fraud. He repeated this performance at another hospital during December.

Hospitals are warned against this man, and in the event that he is seen he should be turned over to the police.

Menu Planning

ELSBETH HENNECKE
Presbyterian Hospital, Chicago

MENU PLANNING is the axis about which the responsibilities of the dietitian rotate. We are frequently asked by the lay person, "Just what are the duties of a dietitian?" and invariably the response is introduced by the statement, "We plan menus for patients, personnel, etc., etc." It is a performance that becomes so much a part of the routine of the dietitian that she continues to remind herself of its importance in order to give it her best attention.

Hospital menu planning falls into two divisions: first, the planning of menus for the patients, and second, the menus for the meals for the personnel. Both are of great importance and require careful consideration, the first because it includes the care and treatment of the patient, and the second because it applies to the general well-being of the attendants to the patient. In menu planning must be included the elements of correct diet requirements, appeal to the patient or personnel, consideration of the organization of the kitchen and equipment available and the cost factor.

In planning the patients' menu there are many points to be taken into consideration. A well balanced meal to supply the physiological needs of the group or of the individual is of prime importance. This calls upon the scientific training of the dietitian, and while she by no means calculates each menu in terms of carbohydrate, protein, or fat, or the other food requirements, she includes these values as she plans along meal by meal. Through experience, she has developed some sixth sense which tells her at a glance whether a menu is correct as to food nutrients. It is well, however, to give an actual check periodically to be assured that the requirements are being met.

The next point to be taken into consideration in menu planning is the appeal to the patients. The meal may be scientifically correct, but if it does not invite the patient's interest all efforts have failed. Meals are being planned for a group of people who are not living under normal conditions or in their usual state of health. What ordinarily might appeal to them, now needs an extra touch to be acceptable. They, as a rule, follow the regular hospital procedure without much comment since it is strange to them, but when it comes to their meals they have more definite ideas as to what they will take and what they will not take. They wait eagerly for meal times, the pleasant break in the day for them, and they must not be disappointed. Appeal to the patient may be effected by attractiveness to the eye. One can generally tell at a glance if a meal set before one is

going to appeal or not. Color combinations enter in here largely. Combinations should be worked out so as to be in good balance. It is not wise or necessary to have a very bland looking tray one meal and an all colorful one the next meal. A combination of cream of celery soup, broiled whitefish, mashed potatoes, creamed cabbage, and a custard may be dietetically correct, but surely most uninteresting in appearance, and would not be likely to tempt a patient's appetite. Had stewed tomatoes been substituted for the cabbage, or fruit jello for the custard, the resulting appearance would have been quite different. There are enough colorful foods available that one need never be at a loss to supply an effect. A sprig of parsley to garnish a meat or egg dish, or a bit of colored jello on a white dessert always pleases the eye.

Lack of variety on menus is apt to be a common complaint, and while the dietitian is more or less restricted in the foods she can use, there are still enough foods and food combinations left to avoid monotony. It is here perhaps that the dietitian's interest and ingenuity is most displayed. To one who is on the constant watch for new ideas, planning menus becomes quite a game. Suggestions for food combinations are very plentiful these days, for many of the larger food houses have home economics sections which specialize in recipe services, and many of these are very worth while. To try to adapt the suggestions offered to the individual institution is an interesting problem.

The element of surprise or of the unusual in a menu is very good. Standard dishes, served in a little different manner, with perhaps new base or a different garnish, can materially change the appearance of the food. Where a written menu is given to the patient, surprise or anticipation can be created by using colorful names listed in the chef's vocabulary, but this should not be overdone, as it may irritate the patient to be uncertain as to what he is ordering. One is inclined to become quite humdrum and use only foods which are entirely "in season" whereas an occasional dish of an "out of season" food may do much to interest the patient. A tempting dish of the season's first strawberries in spring may seem to be an extravagance, but the effect upon the patient may more than justify its use, and the budget can be balanced in some later meal.

It should be the dietitian's desire to plan meals for each patient individually. Unfortunately this cannot be done, except possibly for the private room patients and those patients on special diets, so a menu must be planned which will fit the needs and desires of the greatest number. Where possible, the use of a selective menu for private room patients is advisable. The addition of another meat course, a second vegetable, and an additional dessert gives a wider choice, and need not increase the cost

appreciably. The patient likes the idea of being allowed to make his own selection. Usually his choice is just what it should be, but he feels better about it than if it had been put before him without question. If in addition, the patients are consulted concerning their menus, the dietitians learn of their idiosyncrasies in regard to foods and perhaps can help them to overcome prejudices. Visiting the patients also gives the dietitian the opportunity to have first hand reaction to the menus.

The consideration of the patient on a special diet calls forth additional ingenuity on the part of the dietitian. The diet order prescribed, just as much as the pharmaceutical prescription, must be taken in full in order to give the best results. If the special diet tray is planned, prepared, and served correct to the minutest detail as far as following the prescription is concerned and the patient does not eat the food, it is just so much effort and food wasted, and no gain to the patient. A bit of questioning of the patient as to his likes and dislikes in advance will eliminate such a situation. Another point in menu planning, which refers especially to the ward patient on the special diet, is the importance of using foods to fit the patient's station in life, so that he can easily continue his diet when he leaves the hospital. It hardly would be fair to serve him expensive or too unusual foods while he is in the hospital and then expect him to carry on when he is at home with a greatly reduced budget. This is an important manner in which the hospital can coöperate with the charities who must furnish the patient's supplies when they are discharged from the hospital.

Menu planning for hospital personnel was placed in a separate division, not because it is a thing apart from the menu planning of patients, but rather to emphasize its importance as a part of the dietitian's obligations. Menus for the meals of nurses and employees should be planned just as carefully and with the same consideration as menus for patients, for these groups do hard physical work, and must be kept in good health. This cannot be done if they are not properly fed. It is easier on the dietary budget to feed them the inferior and cheapest foods, or always leftovers, forgetting food balance, but the result is likely to be seen in increased medical attention for these people or decreased efficiency. Another result is that it encourages dishonesty, for these people will manage to get food somehow, usually from serving kitchens where they have no business to be. It is far better to plan good wholesome food, not necessarily elaborate, but sufficient and satisfying.

In planning for patients, one plans for a group whose average length of stay in the hospital is 11 days. In planning for personnel, one plans for a group who are boarders for months and years at a time, some of them having very few meals outside the hospital dining room. One of

the aims of the hospital is the teaching of health measures to the community. Where better can a start be made than with the students and employees, teaching them by example correct dietary habits. Properly fed employees take on a healthier attitude toward their work and their institution, which is reflected not only in their increased efficiency, but toward their patients as well. A healthy, happy employee is a good advertisement for the hospital.

Planning the menu affects not only those who are to partake of the food, but also those who are to assist in its preparation. These people are also kept in mind, for economy of labor should be a consideration. By this is not meant to cut down on the amount of work to be done, but to plan so as to distribute it evenly among the group. It is not necessary to overload the salad girl with work one day and the pastry cook the next. The menus can be so planned as to allow an even distribution of labor.

Equipment is also a factor in menu planning; meals should be planned so as not to have each item on the menu requiring the use of the same piece of equipment. It is not possible to turn out a good dinner when all the foods have required the use of the oven if we have insufficient space. Or to plan a lunch of lamb chops and toasted sandwich when both require last minute use of the broiler. Too much last minute preparation on top of the stove would also result in an unsatisfactory meal. Limitations in equipment sometimes makes for difficulty in menu planning as well as difficulty of preparation.

The cost factor in menu planning is one with which we are forever struggling. With the decreased income of the hospital in the past few years, economies were first directed to the food department. With the present upward trend in food prices must come another adjustment. Now, as never before, the dietitian must be alert to market conditions, must know how these conditions affect her budget, so that at a glance she can determine just what she may use. There are many ways of executing financial economy, in menu planning, but most important is to set a good food standard and to work around it. The use of extras will depend upon the budget allowed.

How are results in menu making judged? Presupposing that the menu planned has been satisfactorily prepared and served, the best method of receiving a reply is to check the patient's acceptance of the meals served by noting the food returned, and by actual consultation with the patient, the doctor, and the nurse. From that may be derived a new starting point. The one who plans menus must ever be on the alert to changing ideas, realize that there is always a new way of saying or doing or preparing the usual thing, and keep up an interest that stimulates to better results.

The San Fernando Plan*

P. BERMAN, M.D.

Medical Director, Los Angeles County Hospital

THE SO-CALLED San Fernando Plan is a method of care for the indigent patients in the smaller communities in the county of Los Angeles, under the direction of the out-patient department of the County Hospital, whereby the patients are treated in the offices of the attending physicians instead of being sent to a county free clinic.

The development of dispensary service in the county of Los Angeles under the direction of the County Hospital dates back to the year 1924 when Dr. R. G. Broderick and Mr. F. E. Chapman, the two experts employed by the Board of Supervisors to survey the needs for expansion of hospital facilities for the care of indigent sick in the county, recommended the establishment of a well equipped out-patient department at the hospital with branch dispensaries in the outlying districts. The out-patient service was started in the same year and has grown rapidly to a very large department of the hospital. The recommendation to establish branch dispensaries in other communities was temporarily disregarded. The constantly increasing demands for medical care for indigents in the presence of the very limited facilities in the old buildings and the problems connected with the planning for a new acute unit have kept the administration too busy to be able to give much consideration to the needs of the communities outside of Los Angeles.

The old institution in the city meanwhile became overcrowded with patients. In due time private clinics, and later private hospitals, were requested to assist in the care of the overflow of patients in the County Hospital. The private clinics were paid at the rate of 50 cents per patient visit, plus additional cost of x-ray, laboratory, special medicine, etc. The private hospitals agreed to care for bed patients at a per diem rate approximating the actual cost of care of such patients in each institution.

During this time the County Health Department began to expand its facilities in the smaller communities and unincorporated areas in the county. Several health centers were established in various localities. These were primarily to serve as branch offices for the Health Department and also to carry out a program of clinic service in preventive medicine. Some of these health centers were equipped for emergency care of sick and injured people in the immediate vicinity of the clinics.

These health centers supplied a service which was greatly needed in the distant sections of the county where no other free clinics were in existence.

*Read before the California State Medical Association.

To meet the demands for medical aid in the various smaller communities these clinics have gradually widened their scope of activity and have finally included in each center a well developed dispensary with many departments similar to those in operation in the out-patient department at the County Hospital. The service, however, in the curative clinics (in contradistinction to the preventive medical work) was limited in many respects. The health officer was unable to dispense certain drugs and medical supplies, which were usually provided free of charge at the County Hospital out-patient department. Not all health centers maintained clinics in some of the specialties or could do certain diagnostic, x-ray and laboratory procedures. In the smaller centers x-ray work was limited to certain days of the week, thus restricting emergency service. Many patients had to be referred to the County Hospital in Los Angeles from distant parts of the county.

In July, 1931, the County Counsel rendered an opinion to the Board of Supervisors to the effect that the Health Department is not authorized legally to render medical aid to persons coming under the provision of the Pauper Act except in cases where treatment is needed to prevent the spread of contagious disease.

Early in 1932 the Bureau of Efficiency of the County of Los Angeles, taking the above opinion in consideration and also as a result of an extensive survey of all departments at the General Hospital, with a view of eliminating duplication and overlapping of medical services in the county and to increase general efficiency, recommended to the Board of Supervisors that all activities in connection with the care of indigent sick in the curative clinics be turned over to the Department of Charities where they legally belong.

The Health Department immediately began to curtail its services in the curative clinics in the various health centers. By the end of the fiscal year 1931-1932, few such clinics remained in full operation. In June, 1932, all the curative clinics, including the emergency stations in the health centers, were ordered transferred from the jurisdiction of the Health Department to that of the Department of Charities. In due time the County Hospital was requested to organize the clinics and operate them as a part of its out-patient service.

The existing attending staff was then reorganized for each health center. The physicians all became members of the attending staff of the County Hospital. A representative of the attending staffs of all the curative clinics was appointed as a member of the medical advisory board of the hospital. A medical social service worker from the hospital staff was placed in each clinic. Instructions were issued making the policies in the

clinics in all respects, including the method of admission of patients, conform with those in effect at the County Hospital. An intern from the hospital house staff was assigned to each clinic.

The number of patients in the various clinics immediately began to increase as it was possible now to transfer patients freely from the out-patient department in the hospital to various clinics in the out-lying districts. A system of close supervision of the work in the clinics was inaugurated. Many conferences were held with members of the various attending staffs, nurses and social service workers, and many changes were made in methods, procedures, and policies. It was felt that the service to the indigent sick in the smaller communities was materially improved.

The administration of the hospital, however, was not entirely satisfied. There were many difficulties which we expected to overcome in the beginning when the service was taken over, but which we were unable to iron out after the first few months. The ordinary faults of the small detached clinic not immediately connected with a hospital were augmented by the fact that close supervision at a distance was difficult.

Patients were making too many visits to the clinics. It was felt that quite often they were seen by the intern without adequate supervision by the attending men. Patients had to wait, sometimes for hours, to see a certain physician and then find that the particular physician could not come to the clinic on that day.

Emergency service rendered in the smaller communities was too expensive. It was found that very few real emergencies were treated in any of the emergency clinics. However, a 24-hour schedule for seven days a week had to be maintained in each place. In some instances this seemed to be an especially extravagant arrangement when not very far from the health center a well equipped, private hospital was in existence, where an adequate 24-hour a day service was maintained, where emergency aid could be secured at any time, and where the patient could remain after the first treatment and not have to be transferred to some other hospital. This was especially obvious when it was found that most of these private hospitals possess already, or could easily secure, a contract with the County Hospital to take care of patients in an emergency.

Physicians after the first few months of service under the jurisdiction of the County Hospital began to object to the fact that too much time was required of each man in the clinic and that, although they were members of the attending staff of the hospital, they could not avail themselves of the privileges and benefits of staff membership. The fact was also stressed that the conditions usually treated at the clinics are rarely of any

special clinical interest to the physician in comparison with the work done by members of the attending staff at the hospital.

It was claimed that during this depression, when incomes have been greatly reduced, physicians should not be required to leave their office for half a day, once or twice a week, to attend to county patients without compensation. It was shown that some of them had actually suffered a loss in their private practice by being out of their offices on their clinic days.

From the many plans advanced to help the above situation, one was decided upon in July, 1933, as a possible remedy. This became known later as the San Fernando Plan. It was to be a radical departure from the accepted method of free medical care for indigent patients and met with many objections from various quarters. However, after many meetings and discussions with county officials it was agreed to put this plan on trial in the city of San Fernando for a period of 90 days.

San Fernando is a small community about 25 miles from the City of Los Angeles, where the first health center was built in 1926 by the County Health Department. It had a well-equipped emergency station including several hospital beds; it was staffed by a small number of attending physicians and had been functioning as a part of the hospital out-patient department for about a year. This clinic was especially fitted for the experiment on account of its comparatively small size, the small staff, and the distance from Los Angeles.

The plan in general was to discontinue sending patients to the health center for treatment but to send them instead to the offices of the various physicians on the staff and to reimburse these physicians for the use of their offices, instruments, nursing care, incidentals, etc., at the rate of 50 cents per patient visit. It simply meant the transfer of the greater part of the expense of overhead in the county clinics to the physicians' offices and paying the physicians at approximately the actual cost of this service. A precedent for a similar arrangement has existed in the county of Los Angeles for many years whereby a certain class of patients from the out-patient department were referred to private clinics. These clinics were paid at the rate of 50 cents per patient visit, which was considered to be approximately the cost of general overhead in the clinic.

In July 1933 an ordinance was adopted by the Board of Supervisors permitting the General Hospital to employ 100 physicians as employees of the hospital, without pay, to take care of indigent patients in their offices, the hospital to reimburse these physicians for the use of their offices, instruments, nursing care, and incidentals at the rate of 50 cents per patient visit and also for x-ray laboratory, and special treatments at approximately the actual cost of such services.

The same ordinance also provided that these physicians may be paid by the county for visits to indigent patients' homes at the rate of $1.50 per visit, plus mileage at the regular rate paid county employees for mileage when their own cars are used.

The hospital was ordered to put the plan immediately into effect and accordingly the following arrangements were made with the clinics in the city of San Fernando, beginning August 1, 1933:

All employees of the hospital, including the nurses, intern, and other help were removed from the clinic and ordered back to the County Hospital. This did not increase our personnel at the hospital, as a certain turnover of employees is expected each month. The few employees from the clinics could easily be absorbed.

The medical social service worker and her clerical assistant were the only ones left in the clinic representing the County Hospital.

The emergency station in the health center was closed. The local police authorities and other interested agencies were notified to bring patients who needed emergency care to a designated private hospital.

The following method of the care of clinic patients was put into effect:

New applicants are seen by the medical social worker in the clinic as was done formerly: their financial status is carefully investigated and, if found to be eligible for care, they are referred to the office of one of the physicians on the attending staff.

Persons not eligible for care are referred, as formerly, to the proper agency where such care may be obtained. Those able to pay for private care are given names of private physicians. When in doubt the medical social worker refers the patient to the physician's office for examination and consults with the physician as to further care.

In the selection of a physician the patients are assigned to the former family physician wherever possible, also members of one family are all sent to the same physician whenever advisable.

The physician is instructed to return a copy of his records of the case to the medical social worker after the patient's first visit. The new patient may then be permitted to continue his care at the doctor's office for four more visits, if needed. After the fifth visit the patient is sent back to the medical social worker for a re-check. If continuation of treatment is recommended by the physician and the patient is still eligible for care, he is given authorization for five more visits.

If consultation in a case becomes necessary the patient is sent to a consultant who is also paid 50 cents for the use of his office, etc.

A consultant must have concurred in the diagnosis before a major operation is decided upon. Such a patient is sent to the County Hospital in

Los Angeles if the operation is not in the nature of emergency treatment; in emergencies the local private hospitals are available for use. The County Hospital pays for the service in the private institution at approximately actual cost.

The attending staff takes care of county patients in contract private hospitals without compensation as they do of the patients in the County Hospital.

An arrangement is made with one or several local drug stores where patients obtain drugs and medication prescribed by the staff physicians. Stock preparations used in the out-patient department of the County Hospital are kept in these drugstores and are dispensed by the druggists on prescription.

When indigent patients require a physician's service in their homes, one of these physicians on the clinic staff may make a home visit and send his bill for $1.50 per visit, plus mileage.

An executive committee in each local attending staff is organized to supervise all activities in the clinics. It consists of the chairman, secretary, one other member of the staff, the social service worker and the assistant medical director in charge of the clinics.

This committee passes on all matters of policy in the local clinic, investigates complaints and reports to the medical director at the County Hospital. It also acts as a membership committee, making recommendations regarding physicians who desire to become members of the staff. It also recommends disciplinary measures to be taken against individual members of the staff when necessary.

There is also an advisory council of the curative clinics, consisting of the chairmen of all the executive committees, who are also chairmen of their respective staffs. The director of the hospital social service department, the medical director, and his assistant at the County Hospital are ex officio members. This advisory council makes recommendations in matters of policy which concern all curative clinics in the county. It also acts as a body to which appeals may be taken from the decision of the local committees. One of the members of this advisory council is annually elected as a member of the advisory board of the attending staff of the hospital.

This plan, after being in operation for 90 days in the city of San Fernando, showed the following advantages:

Patients are apparently receiving better medical attention and their care is supervised more closely by members of the attending staff. There is much greater interest shown by the physicians in their patients. There is

close coöperation with the medical social worker in transmitting recommendations and seeing that necessary treatment is carried out.

A great decrease in the number of patient visits in each clinic is noticed. This is due partly to the fact that only actual examinations and treatments by an attending man are considered as clinic visits. Interviews by the medical social worker or any other employee of the hospital are not counted as visits.

A number of applicants in the clinics have become private patients of the physicians to whom they were sent for care.

The so-called "clinic shoppers" and those who like to go to the clinic for its "social" value do not care to go to the physicians' offices. In fact, such cases are promptly discharged by a physician after the first or second visit and are taken off our lists.

Patients do not have to wait for hours in the clinics but are taken care of in the same manner as private patients are in doctors' offices.

Emergency cases are given prompt care in the private hospitals. A great percentage of such cases become private patients of the attending physician, thus greatly reducing the cost to the county.

Severely injured patients can remain in the hospital and do not have to be transported to another institution soon after an operation.

The large number of patients who have swelled our clinics in the last couple of years and who do not belong to the ordinary pauper class but are temporarily victims of the depression are not sent to a public clinic but are placed in the office of a physician. These patients appreciate the privilege of going to a private doctor's office. They will probably continue with the same physician as private patients when general conditions improve.

A certain amount of money was actually saved by the county.

The difficulties of this plan are the ordinary difficulties encountered when a new method of care of a large number of indigent patients is put into effect.

One of our problems is to teach a large group of physicians to practice medicine in accordance with hospital methods. Many meetings with the various staffs have been taken up by discussions of what to prescribe and how to prescribe. Physicians occasionally insist on using costly proprietary drugs when similar official preparations could be used at very little expense.

The keeping of proper records and the making of necessary reports by the various members of the staff is another problem with which some of the physicians have difficulties.

The supervision of the laboratory procedures in the various doctors'

offices is not an easy matter but is working out well in the last few months. Physicians have learned that they cannot request more laboratory work for these indigent patients than they would for their own private patients.

Occasionally a physician has to be especially supervised in the methods he is using in taking care of our patients in his office.

Complaints from patients are practically nil, in fact the only complaint that has reached my office in the last several months was from patients who claim that they miss the "social" side of the clinic.

After the trial period of 90 days in San Fernando, the Board of Supervisors ordered the hospital to extend the service in accordance with this plan to several other health centers in the county. At the present time eight such clinics are in operation in the county of Los Angeles. Plans are being made to extend this plan county-wide to cover all the smaller communities.

It is the opinion of those who have kept in close touch with activities of the various clinics in the Los Angeles County out-patient department for the last several years that, with careful supervision, the San Fernando Plan will prove a success and a great improvement over the old method of caring for the indigent sick by the county of Los Angeles.

Tests of Red-Lead Paints

Five and one-half years ago a large number of steel panels painted with two coats of red-lead paints were exposed on the roof of the chemistry building at 45° facing south. The formulas consisted of 20, 22, 25, 28, 30, 33, 35, and 40 pounds of red lead (95% grade) to 1 gallon of boiled linseed oil (no thinner or drier added). Thus far the paints have failed exactly in order of increasing amount of red lead, the first one to fail being the paint composed of 20 pounds of red lead to 1 gallon of oil. At this time (5½ years' exposure), the paint composed of 28 pounds of red lead to 1 gallon of oil has failed (rusting). The 30-, 33-, 35-, and 40-pound paints are still in good condition.—*Technical News Bulletin,* U. S. Dept. of Commerce.

Relief Funds Used to Pay for Hospital Care

In Illinois and New Jersey, hospitals now have the advantage of being paid by state (not federal) relief funds for care of the unemployed and their families. The following account of what has been accomplished in these states may be of help to state and local hospital associations elsewhere.

Illinois

The Illinois Emergency Relief Commission has in operation a plan whereby non-government hospitals are paid for caring for relief cases. Payment is on a per diem basis. The funds are state relief money. The plan takes two forms, one in Cook County, including Chicago and outlying territory, the other in the rest of the state.

In Cook County, hospitals complying with certain requirements are paid at the rate of $3.75 per day for each in-patient day's care whose family is on the relief rolls. At the present time 17 hospitals in Cook County participate in this plan. Each hospital has allocated a certain number of beds, ranging from 10 to 50, depending upon the scope, size, and location of the hospital. A total of 476 such allocated beds are now used to capacity in behalf of relief cases. In August, nearly 14,000 days' care was paid for by the Commission in these hospitals, a total of almost $52,000.

A similar plan applies to clinics in Chicago providing out-patient service for relief cases. Payment is made to clinics—mostly out-patient departments of hospitals—on an approved list at the rate of 65 cents per visit. In August, 1934, approximately 30,000 were thus paid for, a total of $19,500.

The plan in Cook County has been developed the past three years as the result of coöperative efforts of the Chicago Hospital Association and the Health Division of the Chicago Council of Social Agencies working with the Illinois Emergency Relief Commission.

In Illinois, outside Cook County, a plan involving similar principles but differing in details is in effect. Under regulations formulated by the Commission in its official bulletin No. 277, issued June 19, 1934, a maximum per diem rate for all hospital cases under the care of the Commission is paid throughout the state outside of Chicago regardless of local hospital costs or charges. This is an inclusive charge covering all ordinary care, nursing, medicines, and tests, except operating room fees and laboratory examinations of an unusual character, special nursing when necessary, and x-rays. For these a special schedule has been agreed upon.

Neither in Chicago nor Cook County are any professional fees paid at the present time to physicians for hospital or out-patient service. At the

present time there are 83 counties with medical programs financed in whole or in part by the Commission. About 40 of these counties have "referral" nurses who interview local applicants for medical care and determine what medical care shall be authorized and who consult with nurses of the Commission service and give advice on problems of medical care. Tabulations for August show that for 75 counties with a case load of 131,508 there were 14,375 families referred for medical care down state. The total cost of this medical care was $86,198, an average of $6 per family receiving such care. There were 1,319 hospital cases, for whose care hospitals were paid $31,894.

The stated policy is to use only hospitals approved by the American College of Surgeons, but actually in some counties there are no hospitals available and in others the Commission is forced to use hospitals not meeting the requirements of the American College of Surgeons. The Commission does not pay for care in clinics down-state. It does meet the expenses of one clinic, however, in Rockford. It appears that this clinic was originally operated by a "county physician." When county funds became inadequate the Commission subsidized the clinic.

New Jersey

The New Jersey Emergency Relief Administration is carrying out a policy under which a per diem is paid for relief cases cared for in non-governmental hospitals. An increase of approximately one million dollars a year in hospital revenues was needed to make up the deficit that was being incurred, it was brought out in a study of hospital financial conditions made by the Emergency Relief Administration headquarters staff. This finding was discussed with a committee of representative hospital superintendents and specific per diem rate schedules were fixed. Hospitals were then invited to file application for recognition as hospitals authorized to care for indigent patients who were being assisted by the Emergency Relief Administration, under a system of regulations formulated jointly by representatives of the Relief Administration and by the Hospital Association.

Hospitals are required to submit statistical and financial reports, and must open their books to audit when required. At periodic intervals, or whenever it appears that readjustment is needed in order to maintain their integrity, the per diem rates are subject to review: in other words, their total shall approximately equal the amount of deficit the institutions would incur should the Emergency Relief Administration contributions be eliminated. The total hospital relief bill paid on a state-wide basis by the Emergency Relief Administration in June amounted to $78,232.95 and in

July this sum was $78,774.55. These payments provide greatly needed financial assistance to the 75 general hospitals in New Jersey, and also provide payment for services rendered to relief clients on an equitable basis.

New Jersey's general hospitals were able to bring about this happy arrangement with the Emergency Relief Administration primarily because of the organized active work of the New Jersey General Hospital Association. For several years Miss Marie Louis of the Muhlenberg Hospital had been presenting the needs of the general hospitals to the public in a very convincing manner.

It should be added that in New Jersey no state funds other than those from Emergency Relief are given to non-governmental hospitals. A legislative commission a few years ago advised against direct state appropriation for this purpose. A state law, however, permits counties which have no county hospitals to assist in maintaining voluntary hospitals located in their areas. The New Jersey State Department of Institutions and Agencies has worked out a basis of coöperation between the counties and the voluntary hospitals, and has established a uniform reporting system of statistics of work and finance.

Pediatric Service in General Hospitals*

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IN THE FOLLOWING SERIES of reports we shall attempt to present at least a partial picture of pediatric care and facilities for that care in the pediatric departments of general hospitals throughout the United States. Questionnaires were sent only to hospitals having at least 24 beds exclusively for children. Bassinets were counted in the pediatric service when the service was under the direction of a pediatrician.

The first report concerns the hospitals in Region I of the Academy of Pediatrics. This region includes the following states: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and the District of Columbia. This particular area is, of course, the most thickly populated in the entire country.

Total beds.—The total number of beds and bassinets by states is as follows:

TABLE 1

State	Number Hospitals	Beds	Bassinets	Hospital with Largest No. Beds	Hospital with Smallest No. Beds	Hospital with Largest No. Bass.	Hospital with Smallest No. Bass.
Connecticut	10	437	422	86	27	100	7
Delaware	1	35	5	0	0	0	0
Maine	4*	56	42	32	24	28	14
Maryland	2	92	56	59	33	35	21
Massachusetts	16**	719	665	188	26	218	8
New Jersey	11	474	395	90	26	98	3
Pennsylvania	36	1,492	2,522	193	24	65	0
Rhode Island	3	237	94	147	42	43	21
New York	50***	3,133	1,403	326	25	127	0
Dist. of Columbia..	2	160	145	100	60	100	45

*2 reported; **15 reported; ***1 did not report.

In the entire region there are 135 hospitals which have a pediatric service of 24 or more beds and bassinets. Four of these did not reply to this part of the questionnaire.

Among all the hospitals we find a total of 6,835 beds for children and 5,749 bassinets. The largest service has 326 beds for children; the smallest, 24. The largest number of bassinets in any one hospital is 218;

*Report of the Committee on Hospitals and Dispensaries of the American Academy of Pediatrics

the smallest, 7. New York State has 50[1] hospitals maintaining at least 24 beds exclusively for children. Pennsylvania has 36. No other state has more than 16 and Delaware reports only one.

Residents.—Among the 131 hospitals considered in this report, 33 employ resident pediatricians. Over half of this number are employed in New York State alone. Twenty-nine residents are employed exclusively in the pediatric department and in most instances they are paid a salary which varies from $25 to $175 per month.

Interns.—The question on internships was designed to reveal the number of instances in which interns served exclusively in the children's department or merely went there for part of a rotating general internship. Several replies were indefinite in this distinction. As far as we could determine, 30 hospitals employ interns on a service confined exclusively to pediatrics. Fifteen such services are in New York. Ninety-four hospitals report that the interns come to the pediatric department as part of the service of a general internship. Three hospitals apparently employ neither residents nor interns. The length of time spent on the service varies from one to six months. In most instances the service is for three months.

Attending staff.—The total number of attending pediatricians for the 131 hospitals is 540. The length of time for these respective services varies from one to 12 months. The majority of the services are for six to 12 months. There are a few services as short as one, two, or three months.

Newborn service.—Sixty-seven hospitals maintain newborn services under the care of the pediatric department. No hospital in Delaware, Maine, or Maryland reports that they have such a service. New York has 26, Pennsylvania 17; no other state has more than 9.

Nursing.—One hundred and sixty-one registered nurses are employed as heads of the pediatric department among these hospitals. Very few employ more than one head nurse and there are a few which have none for that department alone. One hundred and twenty-one of these head nurses have had special pediatric training. In many instances, however, the special training has consisted of only a three month course or even less. Pupil nurses serve in the pediatric department in practically all of the hospitals. The usual length of the service is three to four months.

As near as can be determined the average ratio of nurses to children and infants was 1:4. In a few instances it ran as high as 1:9 or 12.

Social service.—Fifty-six hospitals maintain a special social service for children. Among these, 42 are in New York and Pennsylvania.

[1]One hospital did not reply to this part of the questionnaire.

Diet kitchen.—One hundred and twenty-five hospitals maintain special diet kitchens for infants; 65 for children.

Schooling and recreation.—Schooling for convalescents is provided in 46 hospitals and 93 provide recreation facilities.

Dispensary.—One hundred and thirteen hospitals maintain a special department for children in the dispensary. In many instances this department is open only two or three times weekly. Average attendance in a few of these dispensaries is as low as four or five patients each session while many have 40 or more. Average attendance is somewhere between 20 and 30 children. Replies to the question concerning clinic attendance did not permit us to compile very accurate figures. The pediatric staff serves in both hospital and dispensary in 104 hospitals. The resident sees service there in 24 instances; the intern in 85.

The following table shows the number of children and newborn cared for by these hospitals in 1933, together with number of deaths, autopsies, and percentage of autopsies and deaths among the newborn and children (Table II).

TABLE II

State	Newborn	Children	Newborn Deaths	Children Deaths	Newborn Autopsies	Children Autopsies	Per cent Newborn Autopsies	Per cent Children Autopsies	Per cent Newborn Deaths	Per cent Children Deaths
Connecticut	6,597	7,338	213	211	51	72	23.9	34.1	3.2	2.8
Delaware	429	1,303	18	26	3	11	16.6	42.3	4.1	1.9
Maine	429	1,303	18	26	3	11	16.6	42.3	4 1	1.9
Maryland	836	1,314	7	66	5	23	71.4	34.8	0.84	5.2
Massachusetts	10,874	15,386	377	440	72	117	19.0	26.5	3.4	2.8
New Jersey	18,829	15,508	369	540	96	130	26.0	24.0	1.96	3.4
New York	38.053	47,346	1,144	2,588	604	1,174	52.7	45.3	3.0	5.4
Pennsylvania	20,456	24,490	695	906	246	323	35.3	35.6	3.3	2.8
Rhode Island	906	1,167	44	89	16	52	36.3	58.4	4.8	7.6
District of Columbia	2,663	2,223	114	204	89	86	78.0	42.1	4.2	9.1
Total	100,105	116,723	2,997	5,082	1,185	1,996	39.5	39.2	2.9	4.3

DISCUSSION

In reading the above report one must bear in mind that 12,584 does not represent the total number of beds and bassinets available for children in the hospitals of Region I. There are many other hospitals in which children are admitted regularly as patients but in which the number of beds and bassinets is less than 24. In the latter hospitals there is probably no regular pediatric service.

There are several interesting facts presented by Table I. Among these, five, or one-half of the states in the region considered, have only 10 hospitals with services for children large enough for consideration under the standard of this report.

The smallest number of beds for children in any one service reported is 24, the largest 326; similarly for bassinets, 0 and 218. The largest children's service is in New York, the smallest in Maine and Pennsylvania. The largest infant (bassinets) service is in Massachusetts (218), the smallest in New Jersey (three). One hospital in both Pennsylvania and New York reports that it has no bassinets which may mean either there are no newborn there or that the pediatric department has nothing to do with that service. New York alone has more 24-bed services than all other states combined, excluding Pennsylvania; New York, 49; all other states combined excluding Pennsylvania, 46. Pennsylvania has 36, only 13 less than New York; New York and Pennsylvania combined, over half or 57% of all such hospitals in Region I. Sixty-seven plus per cent of all beds are in these two states, 68 plus per cent of all bassinets. These figures are accounted for by the relatively large population of these two states.

Comparatively few of the hospitals employ a pediatric resident; this is to be expected, since there are few large pediatric departments among these hospitals. We have no information concerning the requirements of qualification for these positions.

In 30 hospitals interns may be employed for one year on the pediatric service. In most instances the service is for three months as a part of a general rotating internship. A few report one month internships. This seems too short a time for practical value either to the hospital or to the intern.

Only 67 hospitals, or 51%, include the newborn service as part of the pediatric department. We feel that the newborn service should always be under the supervision of the pediatric department.

Only a few hospitals lack a head nurse whose duties are limited to the pediatric department. In most instances only one head nurse is employed. Among the 161 nurses reported employed in this capacity 40 have not had special pediatric training and in many other instances special training has consisted of only three month or shorter courses. We fail to see how these individuals can properly qualify for duties as a head nurse in the care of infants and children.

In practically all of the hospitals there seem to be enough nurses for adequate care as far as number is concerned; as to the efficiency of their training we have no information.

Only the larger hospitals have social service departments which confine their duties to children alone. Of the 56 departments reported 42 are in New York and Pennsylvania.

A surprisingly large number of hospitals (125) report special diet

kitchens for infants. This large number is probably accounted for by the fact that formula or milk "labs" are counted as diet kitchens.

Eighty-five hospitals report no facilities for schooling and 38 no facilities for recreation. Part of the shortcoming in these important activities is probably accounted for by the fact that the services are relatively quite small and very few children are confined to the hospital for long periods of time.

Section II

The second report concerns hospitals in Region II of the American Academy of Pediatrics. Only hospitals having at least 24 beds for children are considered. Bassinets are included in the pediatric service when that service is under the direction of a pediatrician.

Region II represents the states of Alabama, Florida, Georgia, Kentucky, Louisiana, North Carolina, Oklahoma, South Carolina, Mississippi, Tennessee, Texas, Virginia, and West Virginia. In this entire region there are only 21 hospitals having an infants' and children's service of 24 or more beds and bassinets.

Table III presents distribution of the respective services by states and the relative sizes of these services.

TABLE III

State	No. of Hospitals	Total Beds	Total Bassinets	Largest No. of Beds in One Hospital	Smallest No. of Beds in One Hospital	Largest No. of Bassinets in One Hospital	Smallest No. of Bassinets in One Hospital
Alabama	2	87	63	48	39	40	23
Florida	2	54	58	30	18	40	18
Georgia	1	38	..	38	38	..	..
Kentucky	3	150	127	90	30	75	26
Louisiana	1	143	69	143	143	69	69
North Carolina	2	88	74	56	32	50	24
Oklahoma	1	215	17	215	215	17	17
South Carolina	1	50	..	50	50	..	..
Tennessee	3	115	62	56	29	30	12
Texas	2	115	54	80	35	30	24
Virginia	1	32	55	32	32	22	22
West Virginia.	2	75	55	40	35	30	25
Total.....	21	1,162	601				

In 12 states and among 21 hospitals, all of the services combined have a total bed capacity of 1,162; bassinets 601. The largest number of beds in any one hospital is 215; the smallest 18. The largest number of bassinets is 75; the smallest 12. Two hospitals do not include bassinets in their report and apparently do not have them. In no state are there more than three 24-bed services. Kentucky and Tennessee each have three. All others have only one or two.

Residents.—Ten of these 21 hospitals employ a full-time pediatric resident. One employs two residents. All pay the resident a salary which varies from $25 to $80 per month. In four instances the pediatric resident does not serve exclusively in the pediatric department.

Interns.—Four hospitals offer a special internship in pediatrics. Sixteen offer rotating internships in which part of the time is spent exclusively in pediatrics. The usual period of the latter service is one, one and one-half, or two months.

Attending staff.—Eighty-five pediatricians comprise the attending pediatric staffs of the 21 hospitals. The number for states varies from three to 16, but only four report eight or more. The period of the respective services varies from two to 12 months. Only one hospital reports a service as short as two months. The majority of the services are for six to 12 months, but six report services of three- or four-month periods.

Newborn service.—Fourteen hospitals maintain their newborn service under the supervision of the pediatric department.

Nursing.—There is a special nurse in charge of the children's department in each hospital. Fifteen of these nurses have had special pediatric training. Among a few, this training has been for a period of only two, three, or four months. Nineteen hospitals have pupil nurses. Their average time of service usually is from two to four months. The average pupil nurse has from two to 10 infants under her care and when in the children's department will care for from three to 10 children.

Social service.—Seven hospitals have a special social service for children.

Diet kitchen.—Fourteen hospitals have a special diet kitchen for infants and 11 have one for children.

Schooling and recreation.—Schooling for convalescents is provided in four hospitals and recreation in five.

Dispensaries.—Nineteen hospitals maintain a dispensary for children. With only a few exceptions these clinics are open daily with attendance varying on the average from 25 to 50 patients. In a few instances, the attendance figure is 10 to 12 patients. In 14 instances the same staff serves in both hospital and dispensary. Residents serve in the dispensary in six of the 10 hospitals having residents, and interns serve there in 13 instances.

Table IV presents figures concerning admissions, deaths, autopsies, and percentage of deaths and autopsies.

COMMENT

Comment will be restricted to this report without comparison with the figures of the first report. Comparative figures from all regions will be discussed in a final report.

TABLE IV
(Year 1933)

State	Newborn Admitted	Children Admitted	Newborn Deaths	Children Deaths	Newborn Autopsies	Children Autopsies	Per cent Newborn Deaths	Per cent Newborn Autopsies	Per cent Children Deaths	Per cent Children Autopsies
Alabama	2,097	2,317	84	163	18	40	4.0	21.4	7.3	24.5
Florida	1,028	430	25	71	4	13	2.4	16.0	16.5	18.1
Georgia	1,434	883	38	52	5	11	2.6	13.1	5.8	21.1
Kentucky	2,298	2,596	136	229	50	68	5.4	36.7	8.8	29.7
Louisiana	3,102	13,277	171	426	..†	..†	5.5	....	3.2	....
North Carolina.	615	1,143	32	62	26*	41	5.4	81.2*	5.4	66.1
Oklahoma	369	1,379	45	156	10	67	12.1	22.2	11.3	42.8
South Carolina..	521	901	41	91	5	14	7.8	12.1	10.0	15.3
Tennessee	1,350	1,181	86	125	19	52	6.3	22.0	10.5	43.2
Texas	866	1,142	62	176	10	35	7.1	16.1	15.4	19.8
West Virginia..	586	1,050	17	45	2	10	2.9	11.7	4.2	22.2
Total.....	14,512	26,675	745	1,631	251	354	5.1	20.2	6.1	21.7

*Includes necropsies on stillborn. †No reply.

The fact is somewhat surprising that in this large area comprising 12 states, only 21 hospitals with pediatric services large enough for consideration in this report are found. Furthermore, among these hospitals there is a seemingly low total of 1,763 available beds and bassinets for infants and children. Several factors probably influence these figures, among them, the economic status, population density, and possibly some backwardness in developing better pediatric departments in the hospitals in this region.

Six hospitals have a pediatric department which they consider large enough and of sufficient importance to warrant the employment of a full-time resident. Ten report that they have a pediatric resident, but in four instances he does not serve exclusively in the pediatric department.

Four hospitals offer special pediatric internships and among 16 institutions offering a pediatric service as part of a general rotating internship, the usual time spent on the service is from one to two months. A rather limited pediatric knowledge would be acquired in one or even two months.

All hospitals have attending pediatricians. There is a total number of 85 for the entire area, or about four per state. There are considerably more than 85 pediatricians in Region II. Allowing for a large group who confine their hospital staff associations to Children's Hospitals, there must remain another considerable group who do not have an opportunity to serve in pediatric departments of sufficient size to afford them valuable experience.

Newborn services should be under the complete or at least partial supervision of the pediatric department, but are not in seven of these institutions.

Nursing is apparently supervised in each of the 21 pediatric services by a graduate nurse. However, according to our information, six of these nurses have not had pediatric training and among a few, their special pediatric training has been for too short periods of time to be of much value.

Pupil nurses are trained in 19 hospitals and the extent of their pediatric training is about the same as that in any general nursing course, that is, from two to four months.

One-third of the hospitals maintain a social service department for children, two-thirds a special diet kitchen for infants, one-half a diet kitchen for children. These figures are gratifying when one considers that many of the children's services are relatively small.

Schooling and recreation for convalescents do not receive much emphasis among these hospitals. Less than one-fifth provide schooling and less than one-fourth recreation.

All hospitals but two maintain a children's department in the dispensary and in general the attendance is good, often being 30 and 40 children per day. In two-thirds of the hospitals, the same pediatric staff serves both hospital and dispensary, but interns and residents are in service there in too few instances.

You may draw your own conclusions after perusal of the fourth table. We merely point out that the total number of children and newborn receiving care in these hospitals during one year is not large. The newborn death rate is commendably low in some, much too high in others. The autopsy percentage figures for both children and newborn show considerable room for improvement in most instances.

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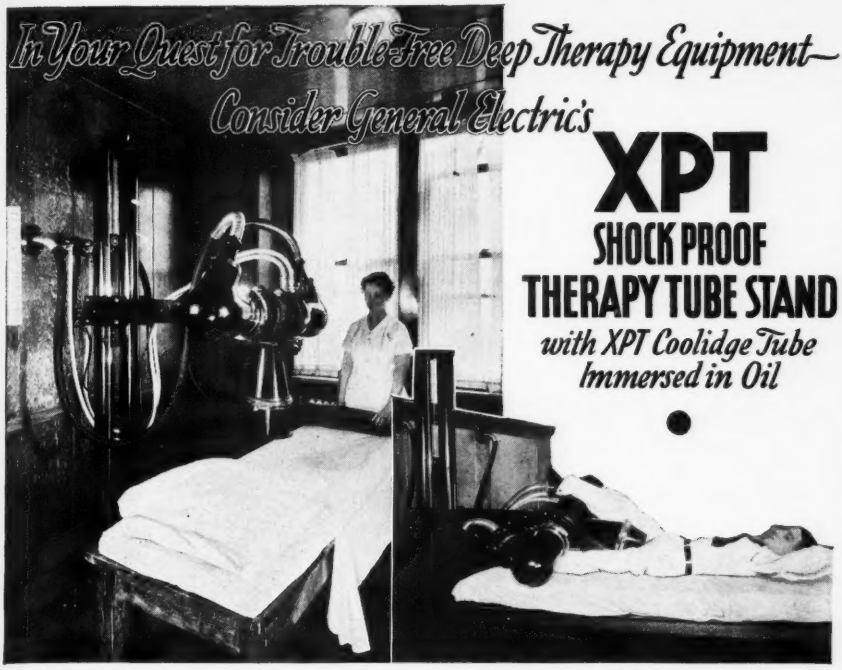

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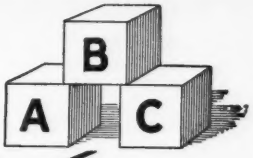

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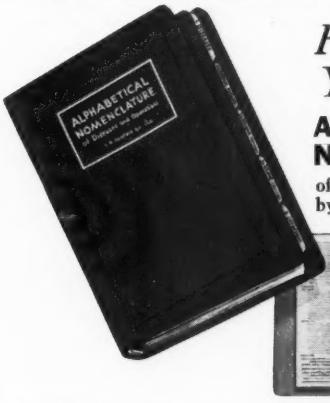

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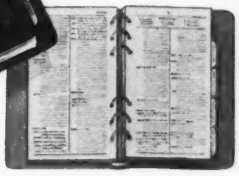

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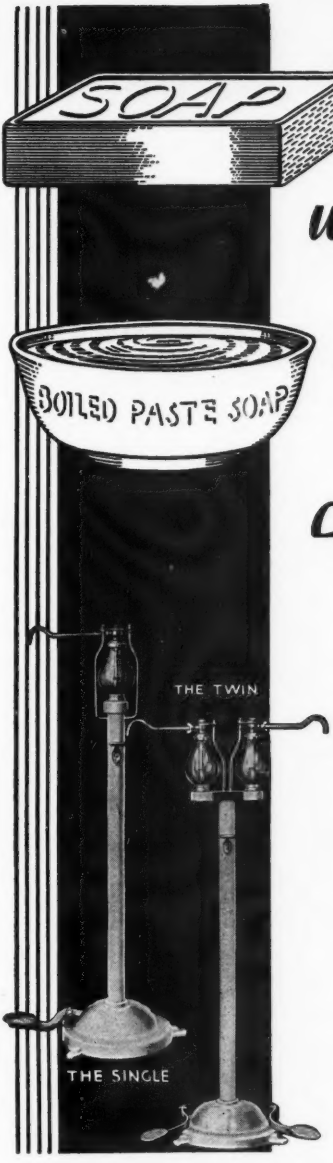

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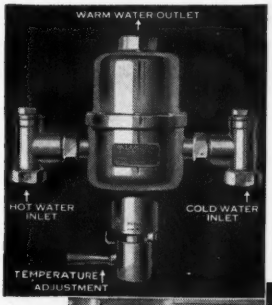

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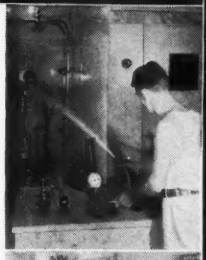

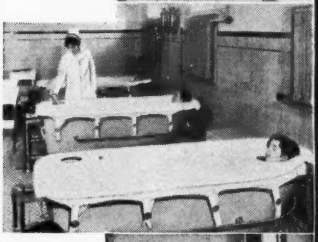

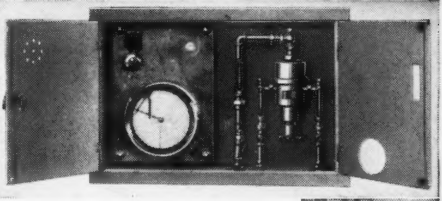

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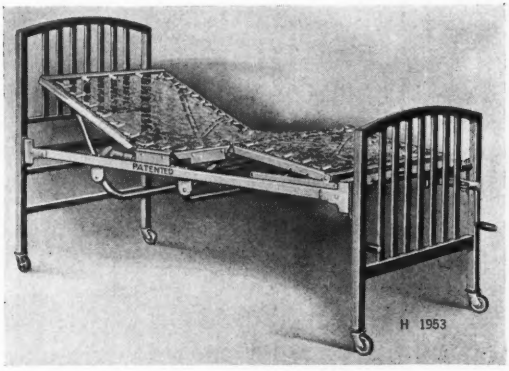

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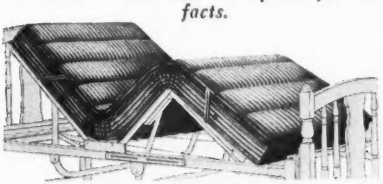

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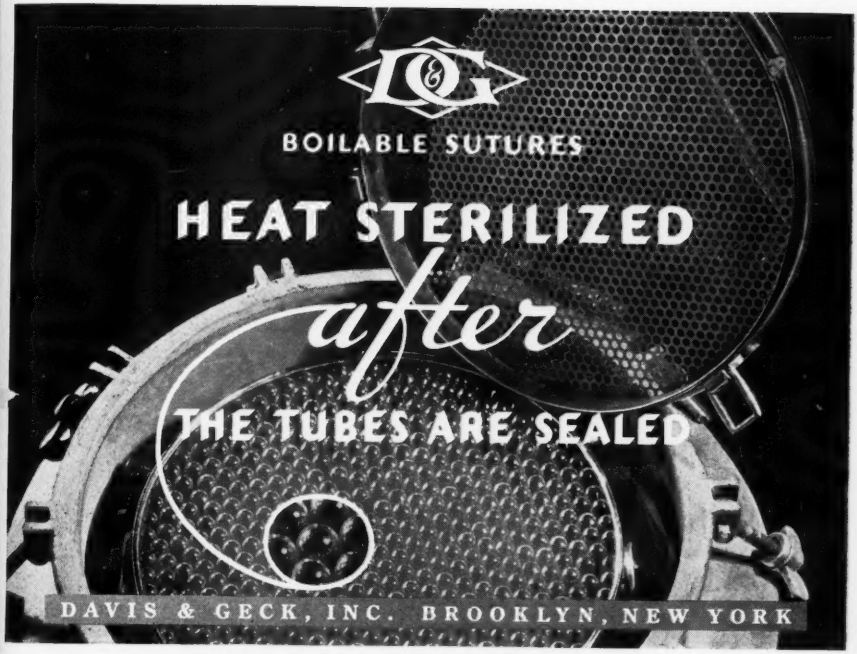
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